Greer, Leslie

From: Martone, Kim
Sent: Friday, July 17, 2015 7:52 AM
To: Hansted, Kevin; Lazarus, Steven; Cotto, Carmen
Cc: Riggott, Kaila; Greer, Leslie
Subject: FW: Greater Waterbury Health Network, Inc. ------ Prospect Medical Holdings, Inc.
Attachments: Scanned from a Xerox multifunction device.pdf

-----Original Message-----
From: Ann H. Zucker [mailto:AZucker@carmodylaw.com]
Sent: Thursday, July 16, 2015 5:16 PM
To: Hawes, Gary W.; Martone, Kim
Cc: dstromstad@wtbyhosp.org; carlcontadini@gmail.com; mmv@bvmlaw.com; thomas.reardon@prospectmedical.com; Garrison De Lee (Legal Department) (Garrison.DeLee@prospectmedical.com); Frank Saidara (frank.saidara@prospectmedical.com); jcain@cainbrothers.com; Chris McDonough (cmcdonough@cainbrothers.com); Jonathan Spees (Jonathan.Spees@prospectmedical.com)
Subject: Greater Waterbury Health Network, Inc. ------ Prospect Medical Holdings, Inc.

Mr. Hawes and Ms. Martone,

Please find attached the Request for Determination with respect to the transfer of certain assets of the Greater Waterbury Health Network, Inc. to Prospect Medical Holdings.
We look forward to working with you again.

Best,
Ann Zucker

Ann H. Zucker
Carmody Torrance Sandak & Hennessey LLP
707 Summer St | Stamford, CT 06901-1026
Direct: 203-252-2652 | Fax: 203-325-8608

50 Leavenworth Street | Waterbury, CT 06702
Direct: 203-784-3108 | Fax: 203-575-2626 mailto:AZucker@carmodylaw.com | http://www.carmodylaw.com

---
IRS CIRCULAR 230 DISCLOSURE. To ensure compliance with requirements imposed by the IRS, we inform you that any U.S. federal tax advice contained in the communication (including any attachments) is not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing, or recommending to another party any transaction or matter addressed herein.

This electronic message contains information from Carmody Torrance Sandak & Hennessey LLP, or its attorneys, which may be confidential, privileged or otherwise protected from disclosure. The information is intended to be used solely by the
recipient(s) named. If you are not an intended recipient, be aware that any review, disclosure, copying, distribution or use of this transmission or its contents is prohibited. If you have received this transmission in error, please notify us immediately at 203-573-1200 or at the reply email address. For more information about Carmody Torrance Sandak & Hennessey LLP, please go to http://www.carmodylaw.com .

PT

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Ann H. Zucker
Partner
Direct: 203.252.2652
Fax: 203.325.8608
azucker@carmodylaw.com

707 Summer Street
Stamford, CT 06901

July 16, 2015

VIA FAX and HAND DELIVERY

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

The Honorable Jewel Mullen
Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Re: Greater Waterbury Health Network, Inc.

Dear Attorney General Jepsen and Commissioner Mullen:

Please be advised that Carmody Torrance Sandak & Hennessey, LLP represents Greater Waterbury Health Network, Inc. and its affiliated entities (collectively, "GWHN") in connection with the proposed transfer of certain assets of GWHN to a subsidiary of Prospect Medical Holdings, Inc. ("Prospect"). Please accept the enclosed Determination Letter submitted by GWHN and Prospect to begin the approval process for the proposed transaction as required under Conn. Gen. Stat. § 19a-486 et seq.

We kindly request that the appearance of Carmody Torrance Sandak & Hennessey LLP be entered for matters conducted both at the Office of the Attorney General and the Department of Public Health, Office of Health Care Access. We look forward to working with your offices on the details of the proposed transaction in order to reach a successful conclusion that will ensure continuity of healthcare services throughout the greater Waterbury community.

Thank you for your consideration and please feel free to contact me if you have any questions.

Very truly yours,

CARMODY TORRANCE SANDAK & HENNNESSEY LLP

By _____
Ann H. Zucker
Its Partner

cc: Darlene Stromstad
President, Waterbury Hospital

Carl Contadini
Chairman, Waterbury Hospital

Garrison DeLee, Esq.
Assistant General Counsel
Prospect Medical Holdings, Inc.

Thomas Reardon
President
Prospect East

Michele Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form 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 this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Greater Waterbury Health Network, Inc.	Prospect Medical Holdings, Inc.
Doing Business As		
Name of Parent Corporation		
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	64 Robbins Street, Waterbury, CT 06708	10780 Santa Monica Blvd., Suite 400, Los Angeles, CA 90025
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP	P
Contact Person at Facility, including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.	Darlene Stromstad, President/CEO	Jonathan Spees, SVP, Corporate Development

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	See above	See above
Contact Person's Telephone Number	203-573-7101	310-696-4738
Contact Person's Fax Number	203-573-6161	(714) 560-7320
Contact Person's e-mail Address	dstromstad@wtbyhosp.org	jonathan.spees@prospectmedical.com

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: **Proposed Transfer of Assets of Greater Waterbury Health Network, Inc. and affiliates to Prospect Medical Holdings, Inc. or its affiliate**

b. Estimated Total Project Cost: **$100 Million (subject to certain adjustments based on the terms of the transaction documents)**

c. Location of proposal, identifying Street Address, Town and Zip Code: **64 Robbins Street, Waterbury, CT 06708**

d. List each town this project is intended to serve: **This project is intended to serve the towns currently served by Waterbury Hospital including Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury.**

e. Estimated starting date for the project: **Following regulatory approval and satisfaction of other closing conditions.**

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and the target population to be served.

PROPOSAL DESCRIPTION

This proposal concerns Greater Waterbury Health Network, Inc. ("GWHN"), which is a Connecticut non-stock, 501(c)(3) corporation that holds interests in numerous entities, joint ventures, and affiliates. GWHN is the parent company of The Waterbury Hospital (the "Hospital"). The Hospital, which was built in 1902, is GWHN's primary asset, and is an acute care facility with 357 licensed beds plus 36 bassinets, located in the heart of Waterbury, Connecticut. The towns served by the Hospital include Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury ("Service Area"). The Hospital is licensed by the State of Connecticut Department of Public Health ("DPH").

Prospect Medical Holdings, Inc. ("PMH") is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates hospitals, including, but not limited to, Roger Williams Medical Center and Our Lady of Fatima Hospital in Rhode Island. PMH is the parent entity to thirteen (13) acute care and behavioral hospitals located in Rhode Island, Texas and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 300,000 patients in southern California, South Central Texas and Rhode Island through a network of over 9,000 physicians. Through PMH's Coordinated-Regional-Care model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives. Through collaboration, PMH strives to provide every patient with the quality, affordable healthcare they need and deserve.

The estimated total project cost is $100,000,000, which is subject to certain adjustments based on the terms of the transaction documents. The proposed transaction will include the following GWHN entities or their assets:

- The Waterbury Hospital, a licensed general Hospital;
- VNA Health at Home, Inc., a licensed home health care agency;
- Greater Waterbury Management Resources, Inc., management company;
- Greater Waterbury Health Services, Inc.
- Alliance Medical Group, Inc., a medical foundation;
- Cardiology Associates of Greater Waterbury, LLC, cardiology medical practice;
- Greater Waterbury Imaging Center, LP;
- Access Rehab Centers, LLC;
- Imaging Partners, LLC;
- Waterbury Gastroenterological Co-Management, LLC;
- Harold Leever Regional Cancer Center, Inc.;
- Heart Center of Greater Waterbury, Inc.; and
- Valley Imaging, LLC.

The proposed transaction is subject to a number of approvals including the consent of GWHN joint venture partners in the case of joint ventures. To the extent required, the Applicants will submit separate CON applications relating to the transfers of certain of the assets.

No services changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the service area towns that have historically been served by GWHN. This proposed transaction will benefit the current employees and communities served by GWHN. Copies of licenses issued by the Department of Public Health to each of the above licensed entities are attached in Exhibit A.

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: **GREATER WATERBURY HEALTH NETWORK, INC.**

Project Title: **Prospect Medical Holdings, Inc.'s Acquisition of Certain Assets of Greater Waterbury Health Network, Inc.**

I, **DARLENE STROMSTAD** , **PRESIDENT**
(Name) (Position – CEO or CFO)

of **GREATER WATERBURY HEALTH NETWORK, INC**. being duly sworn, depose and state that the **GREATER WATERBURY HEALTH NETWORK, INC**
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge.

Darlene Stromstad 7/16/15
Signature Date

Subscribed and sworn to before me on 7/16/15

Jean Balzarini
Notary Public/Commissioner of Superior Court

My commission expires: 7-31-16

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: **PROSPECT MEDICAL HOLDINGS, INC.**

Project Title: **Proposed Transfer of Assets of Greater Waterbury Health Network, Inc. and affiliates to Prospect Medical Holdings, Inc. or its affiliate**

I, **Samuel Lee**, **CEO**
(Name) (Position – CEO or CFO)

of **PROSPECT MEDICAL HOLDINGS, INC**. being duly sworn, depose and state

that the **PROSPECT MEDICAL HOLDINGS, INC.**
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge.

Signature 7/16/2015
Date

Subscribed and sworn to before me on _____

E. Sweeney
Notary Public/Commissioner of Superior Court

My commission expires: 5/9/2018

P/c. all attached 2015 CA Jurat.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California,
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 16th day of July, 2015, by Jang Burn Lee

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

(Seal)

Signature E. Lucas

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0060

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Waterbury Hospital of Waterbury, CT d/b/a Waterbury Hospital is hereby licensed to maintain and operate a General Hospital.

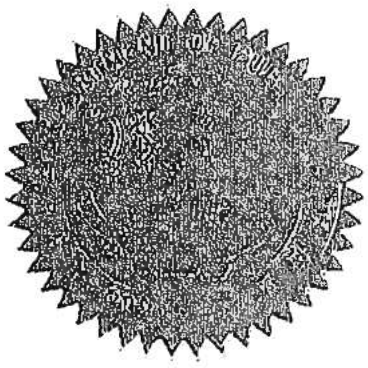
Waterbury Hospital is located at 64 Robbins Street, Waterbury, CT 06721.

The maximum number of beds shall not exceed at any time:

36 Bassinets
357 General Hospital Beds

This license expires **September 30, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2013. RENEWAL.



Jewel Mullen, MD, MPH, MPA
Commissioner

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Ann H. Zucker
Partner
Direct: 203.252.2652
Fax: 203.325.8608
azucker@carmodylaw.com

707 Summer Street
Stamford, CT 06901

July 16, 2015

VIA FAX and HAND DELIVERY

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

The Honorable Jewel Mullen
Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Re: Greater Waterbury Health Network, Inc.

Dear Attorney General Jepsen and Commissioner Mullen:

Please be advised that Carmody Torrance Sandak & Hennessey, LLP represents Greater Waterbury Health Network, Inc. and its affiliated entities (collectively, "GWHN") in connection with the proposed transfer of certain assets of GWHN to an subsidiary of Prospect Medical Holdings, Inc. ("Prospect"). Please accept the enclosed Determination Letter submitted by GWHN and Prospect to begin the approval process for the proposed transaction as required under Conn. Gen. Stat. § 19a-486 et seq.

We kindly request that the appearance of Carmody Torrance Sandak & Hennessey LLP be entered for matters conducted both at the Office of the Attorney General and the Department of Public Health, Office of Health Care Access. We look forward to working with your offices on the details of the proposed transaction in order to reach a successful conclusion that will ensure continuity of healthcare services throughout the greater Waterbury community.

Thank you for your consideration and please feel free to contact me if you have any questions.

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Very truly yours,

CARMODY TORRANCE SANDAK & HENNNESSEY LLP

By _____
Ann H. Zucker
Its Partner

phh

cc: Darlene Stromstad
President, Waterbury Hospital

Carl Contadini
Chairman, Waterbury Hospital

Garrison DeLee, Esq.
Assistant General Counsel
Prospect Medical Holdings, Inc.

Thomas Reardon
President
Prospect East

Michele Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form 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 this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Greater Waterbury Health Network, Inc.	Prospect Medical Holdings, Inc.
Doing Business As		
Name of Parent Corporation		
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	64 Robbins Street, Waterbury, CT 06708	10780 Santa Monica Blvd., Suite 400, Los Angeles, CA 90025
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP	P
Contact Person at Facility, including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.	Darlene Stromstad, President/CEO	Jonathan Spees, SVP, Corporate Development

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	See above	See above
Contact Person's Telephone Number	203-573-7101	310-696-4738
Contact Person's Fax Number	203-573-6161	
Contact Person's e-mail Address	dstromstad@wtbyhosp.org	jonathan.spees@prospectmedical.com

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: **Prospect Medical Holdings, Inc.'s Acquisition of Certain Assets of Greater Waterbury Health Network, Inc.**

b. Estimated Total Project Cost: **$100 Million**

c. Location of proposal, identifying Street Address, Town and Zip Code: **64 Robbins Street, Waterbury, CT 06708**

d. List each town this project is intended to serve: **This project is intended to serve the towns currently served by Waterbury Hospital including, but not limited to, Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury.**

e. Estimated starting date for the project: **First Quarter 2016**

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and the target population to be served.

PROPOSAL DESCRIPTION

This proposal concerns Greater Waterbury Health Network, Inc. ("GWHN"), which is a Connecticut non-stock, 501(c)(3) corporation that holds interests in numerous entities, joint ventures, and affiliates. GWHN is the parent company of The Waterbury Hospital (the "Hospital"). The Hospital, which was built in 1902, is GWHN's primary asset, and is an acute care facility with 357 licensed beds plus 36 bassinets, located in the heart of Waterbury, Connecticut. The towns served by the Hospital include, but are not limited to, Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury ("Service Area"). The Hospital is licensed by the State of Connecticut Department of Public Health ("DPH"). A copy of the Hospital's DPH license is attached as Exhibit A. **[Need a copy of this]**

Prospect Medical Holdings, Inc. ("Prospect"), is a Delaware corporation based in Los Angeles, California; it is privately held company. Prospect is a health service company that owns and operates 13 hospitals, with a total of approximately 2,258 licensed beds, and a network of 32 primary and specialty care clinics in Southern California, San Antonio, Texas, and Rhode Island.

The proposed transaction is the acquisition of substantially all of the assets of Greater Waterbury Health Network, Inc. by a subsidiary of Prospect for a cash payment of $45 million and a commitment to expend no less than $55 million dollars on capital items and the development and improvement of services in the greater Waterbury community.

No changes in services are being proposed. After the acquisition, the hospital and its affiliates will continue to serve the residents of the Service Area.

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: **GREATER WATERBURY HEALTH NETWORK, INC.**

Project Title: **Prospect Medical Holdings, Inc.'s Acquisition of Certain Assets of Greater Waterbury Health Network, Inc.**

I, **DARLENE STROMSTAD** , **PRESIDENT**
(Name) (Position – CEO or CFO)

of **GREATER WATERBURY HEALTH NETWORK, INC**. being duly sworn, depose and state that the **GREATER WATERBURY HEALTH NETWORK, INC**
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge.

Darlene Stromstad 7/16/15
Signature Date

Subscribed and sworn to before me on 7/16/15

Jan Balzarini
Notary Public/Commissioner of Superior Court

My commission expires: 7-31-16

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: **PROSPECT MEDICAL HOLDINGS, INC.**

Project Title: **Proposed Transfer of Assets of Greater Waterbury Health Network, Inc. and affiliates to Prospect Medical Holdings, Inc. or its affiliate**

I, **Samuel Lee**, **CEO**
(Name) (Position – CEO or CFO)

of **PROSPECT MEDICAL HOLDINGS, INC.** being duly sworn, depose and state

that the **PROSPECT MEDICAL HOLDINGS, INC.**
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge.

Signature 7/16/2015
Date

Subscribed and sworn to before me on _____

E. Sueos
Notary Public/Commissioner of Superior Court

My commission expires: 5/9/2018

Pls. see attached 2015 CA Jurat.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 16th day of July, 20 15, by Tang Burn Lee x x,
proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

(Seal)

Signature E. Lucas

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0060

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Waterbury Hospital of Waterbury, CT d/b/a Waterbury Hospital is hereby licensed to maintain and operate a General Hospital.

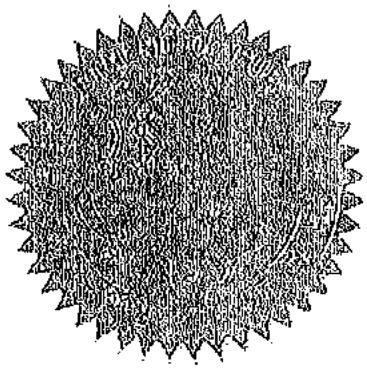
Waterbury Hospital is located at 64 Robbins Street, Waterbury, CT 06721.

The maximum number of beds shall not exceed at any time:

36 Bassinets
357 General Hospital Beds

This license expires **September 30, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2013. RENEWAL.



Jewel Mullen, MD, MPH, MPA
Commissioner

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

July 17, 2015

VIA OVERNIGHT MAIL

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

The Honorable Jewel Mullen
Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Greater Waterbury Health Network Inc.'s proposal to transfer certain assets to Prospect Medical Holdings, Inc. or its affiliate

Dear Attorney General Jepsen and Commissioner Mullen:

We respectfully request that you enter the appearance of Bershtein, Volpe & McKeon PC, on behalf of Prospect Medical Holdings, Inc. for all matters coming before both the Office of the Attorney General and the Department of Public Health, including its Division of Office of Health Care Access.

Sincerely,

Bershtein, Volpe & McKeon PC

By _____
Michele M. Volpe

RECEIVED
JUL 21 2015
Department of Public Health
Office of the Commissioner

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, August 06, 2015 3:18 PM
To: 'dstromstad@wtbyhosp.org'; 'jonathan.spees@prospectmedical.com'; Ann H. Zucker (AZucker@carmodylaw.com)
Cc: michelemvolpe@aol.com; Lazarus, Steven; Martone, Kim; Riggott, Kaila; Hansted, Kevin; Cotto, Carmen; Hawes, Gary W.
Subject: DN: 15-32017-486 and DN: 15-486-02
Attachments: 15-32017-486 and 15-486-02_201508061353.pdf

Tracking:

Recipient	Delivery
'dstromstad@wtbyhosp.org'	
'jonathan.spees@prospectmedical.com'	
Ann H. Zucker (AZucker@carmodylaw.com)	
michelemvolpe@aol.com	
Lazarus, Steven	
Martone, Kim	Delivered: 8/6/2015 3:18 PM
Riggott, Kaila	
Hansted, Kevin	
Cotto, Carmen	
Hawes, Gary W.	Delivered: 8/6/2015 3:18 PM

Please see the attached application for hospital conversion process for Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. (DN: 15-32017-486 & AG's DN: 15-486-02.) Any questions, please contact Steven W. Lazarus @ (860) 418-7012 or Gary Hawes @ (860) 808-5020.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

GEORGE JEPSEN
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of the Attorney General
State of Connecticut

August 6, 2015

VIA ELECTRONIC MAIL AND FACSIMILE
Darlene Stromstad, President & CEO
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Jonathan Spees, Senior Vice President
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, California 90025

Re: Greater Waterbury Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. - OHCA Docket No. 15-31217-486 and Attorney General Docket No. 15-486-02

Dear Ms. Stromstad and Mr. Spees:

After our review of the certificate of need determination letter submitted by you, dated July 16, 2015, we have determined that the proposed transfer of certain assets of the Greater Waterbury Health Network, Inc. ("GWHN") to Prospect Medical Holdings, Inc. ("PMH") requires approval pursuant to Conn. Gen. Stat. § 19a-486 et seq.

Accordingly, the parties to the proposed asset purchase (the "Asset Purchase") shall submit to the Commissioner of Public Health (the "Commissioner") and to the Attorney General, within sixty (60) days of the date of the mailing of this application form, an application for approval of the Asset Purchase. Please mail two (2) complete hard copies and two (2) complete electronic copies of the application for approval to the following address:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Please mail seven (7) complete hard copies and three (3) complete electronic copies of the application for approval to the following address:

Commissioner of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Kevin Hansted, Staff Attorney

We request that your application for approval include the following information (Conn. Gen. Stat. § 19a-486a(c)), address the following issues (Conn. Gen. Stat. §§ 19a-486c and 19a-486d), and be presented in substantially the following format:

1. Identify the contact information for GWHN and PMH, including the individual(s) to whom the Attorney General and the Department of Public Health shall submit bills for contracts with experts or consultants.

2. Provide an executive summary of the application for approval.

3. Describe the terms of the proposed Asset Purchase. This section should include, but is not limited to:

   a. descriptions of GWHN, PMH, the assets to be transferred pursuant to the Asset Purchase, any assets excluded from transaction, the assumed and excluded liabilities of the Asset Purchase, any commitment to spend funds on capital items, and any plan to expand or acquire new programs or services;

   b. a financial analysis of the proposed transaction that identifies the source of funding for PMH's initial purchase price, the uses of the proceeds of the transaction, and the valuations of included and excluded assets; and

   c. a balance sheet of the proposed transaction that lists the assets and liabilities of the nonprofit hospital as of the most recent quarter end, and then sets forth the projected balance sheets of the surviving nonprofit entity, if any, and of the for-profit purchaser that reflect the agreement of the parties regarding the assets and liabilities retained and assumed by the respective parties post-close.

4. Provide copies of all contracts, agreements, memoranda of understanding, and pro forma financial statements relating to the proposed Asset Purchase.

5. Describe the due diligence undertaken by GWHN in deciding to enter into the Asset Purchase. This section should include, but is not limited to, considerations regarding the current financial condition of GWHN and any projected financial condition of GWHN, any professional assessments of or reports regarding GWHN or PMH, any and all alternatives explored by GWHN or other offers received by GWHN, the reasons for rejecting such alternatives and offers, GWHN's selection of PMH, and the specific terms of the Asset Purchase. In addition, the parties should discuss the due diligence in obtaining the fairness evaluation required by Conn. Gen. Stat. § 19a-486a(c)(5), including providing a copy of said independent expert's resume or other documentation of his or her qualifications and describing the process undertaken to identify and retain this person as an independent expert.

6. Describe any and all potential conflicts of interest between, among, or pertaining to, at a minimum, any and all board members, officers, key employees, and experts of GWHN, PMH, any other party to the transaction, and any person or entity that performed assessments requested in this application. In addition, describe the due diligence taken to determine the existence of any conflicts of interest, including how GWHN and PMH defined "conflict of interest" for purposes of the response to this question.

7. Provide an assessment of the fair market value of the transaction, including, but not limited to, a discussion regarding whether the fair market value of GWHN's assets has been manipulated. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment. Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

8. Provide an assessment of whether the transaction will place GWHN's assets, including but not limited to Waterbury Hospital, at unreasonable risk. Provide copies of all documents and statements, financial and otherwise, in support of this assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

9. Provide an assessment of whether any managerial contracts to be entered into are for reasonable fair value. Provide copies of the managerial contracts and of all documents and statements, financial and otherwise, in support of the fair value assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

10. Describe the entity to which the fair market value of GWHN's assets will be transferred, including the funding of the entity, its corporate structure, governance and membership, and the charitable purpose of the entity. Provide copies of documents related to the creation, structure, and purpose of the entity.

11. Identify any and all assets of GWHN that are subject to a charitable use restrictions imposed by a donor and the intended handling of those assets as a result of the proposed Asset Purchase. Please provide a listing of these assets in Microsoft Excel format. Also, please provide copies of the original gift instruments for each gift identified. Only one hard copy of the gift instruments needs to be produced to the Attorney General.

12. Provide copies of all correspondence, memoranda, and any other documents that include the terms of any other offers to transfer assets or operations or change control of operations received by the Hospital.

13. Provide a copy of a fairness evaluation by an independent person who is an expert in such Asset Purchases that includes the expert's evaluation of each of the criteria set forth in Conn. Gen. Stat. § 19a-486c(a). Also provide copies of the information and documents relied upon by the expert in the preparation and issuance of the fairness evaluation.

14. Please provide a copy of the transcript for the informal hearing required by Conn. Gen. Stat. § 19a-486a(c).

15. Explain how GWHN determined the need for the Asset Purchase and discuss the benefits of this Asset Purchase for Waterbury Hospital (the "Hospital") (provide discussion on history and time-line).

16. Provide a listing of the Hospital's current service lines and service locations and describe any planned changes to either the service lines or service locations as a result of the Asset Purchase. Provide an explanation for each change and detail how the hospital's affiliation with PMH will aid in service line development.

17. Describe the existing populations served by the Hospital and how the Asset Purchase will affect these populations. Include demographic information.

18. How will the for-profit nature of PMH affect the provision of health care in the community?

19. Provide a transition plan for the Asset Purchase and describe how GWHN and PMH (collectively, the "Applicants") will ensure continuity of care and hospital services through this plan.

20. Understanding that the proposal is for PMH to exercise ownership over the Hospital, how will care be coordinated care between the Hospital and its various affiliates? Please explain in detail how care coordination efforts will be aided by the proposed Asset Purchase (i.e., how they will be different from GWHN's present efforts). Provide any written plans documenting this coordinated approach to care for the patient population served.

21. Provide a description of the relationship between the proposal and the Statewide Health Care Facilities and Services Plan.

22. Please explain how the post transaction GWHN will address the needs of service area residents with respect to prevention and treatment of diseases and conditions in relation to the Hospital's most recent Community Health Needs Assessment ("CHNA") and the priority of needs listed therein. Please provide a copy of the most recent CHNA.

23. Provide a description of plans that the Applicants will implement to control cost, such as discharge care coordination, implementation of electronic medical records and emergency department triaging to the appropriate level of care. In responding to this

question, report any anticipated savings from the following expense categories for the Hospital: salaries and wages, fringe benefits, contractual labor fees, medical supplies and pharmaceutical costs, depreciation and amortization, bad debts, interest expense, malpractice expense, utilities, business expense and other operating expenses.

24. Provide a description of the Applicants' plans to continue to provide services to the uninsured and underinsured. In responding to this question, please describe any changes to the Hospital's current charity care, uncompensated care and financial assistance policies and procedures, and hospital bed funds that will result from the Asset Purchase. Describe any plans Applicants have to work with other providers in the community, such as federally qualified health centers or community health centers, to provide specialty care to patients, or low cost programs that the Applicants will provide in the area that are tailored toward the uninsured or underinsured.

25. Submit a list of all key professional, administrative and clinical department heads related to this proposal. Additionally, provide a copy of the Curriculum Vitae of each individual listed.

26. Provide evidence as to how the Asset Purchase will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons.

27. Provide the corporate organizational chart prior to and after the proposed Asset Purchase, including all affiliates. For the organizational chart that depicts the post-Asset Purchase structure, working upward on the chain of ownership from the Hospital, please: (i) describe the nature of the ownership and control that each entity has in the entity directly below it; (ii) describe the major business activities/functions of each entity; (iii) provide the principal place of business address for each entity; and (iv) provide the name and business address of each individual currently serving as a member of the governing body of each entity.

28. Please provide the date on which the Hospital filed audited financial statements with OHCA. Applicants may reference these statements in responding to questions. In addition, provide a copy of PMH's most recent audited financial statements.

29. List all funding or financing sources for the $100,000,000 in project costs (the "Project Costs") estimated for this acquisition by PMH. 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.

30. Indicate whether PMH has developed a plan to invest in facility improvements, general upgrades and renovations, deferred maintenance, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff at the Hospital (a "Capital Plan"). If yes, please provide a copy of the Capital Plan.

31. Please describe the extent to which the Project Costs related to this proposal may be adjusted for each of the following:

    a. outstanding indebtedness;
    b. pension liabilities;
    c. retiree health benefits;
    d. captive insurers;
    e. capital leases;
    f. asbestos abatement; and
    g. joint venture interests that may not transfer.

32. How, if at all, will non-approval by any of the joint venture interests referred to in Question 31(g) above affect the Asset Purchase?

33. Please explain in detail the terms of any Capital Plan and in particular:

    a. how funds will be allocated for these purposes, including any projected annual amounts;

    b. the capital projects for the Hospital that are deemed top priorities by the Applicants;

    c. the service improvements for the Hospital that are deemed top priorities by the Applicants;

    d. a list of capital projects and service improvements that are expected to be carried out within the first three years following the closing date; and

    e. discuss the ability of GWHN to address items listed in subsections 31(b) and 31(c) without the approval of this proposal.

34. Describe in detail how this proposal will affect the financial strength of the State's health care system and will be financially feasible.

35. Please provide the current payer mix for the Hospital and the projected payer mix for the Hospital after the Asset Purchase (based on the number of patients, not based on revenue) in the following reporting format:

Table 1: Patient Population/Payer Mix

Payer	Current FY 20__**		Projected					
			FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

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

36. Provide the assumptions used to project the patient population/payer mix after the proposed Asset Purchase.

37. Please provide one year of actual results and three years of projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

    a. Financial Worksheet (C) – for the Hospital only (not inclusive of affiliates), GWHN and PMH without the CON project (columns 1, 2 5, 8 & 11) with the CON project and incremental to the CON project (remainder columns); and

b. Submit Financial Worksheet (C) using the same page and print layouts (size, font, page orientation, margins, etc.) as provided by OHCA.

Note that the actual results for the fiscal year reported in the first column must agree with the GWHN and the Hospital's audited financial statements. The projections must include the first three full fiscal years of the project.

38. Provide the assumptions utilized in developing Financial Worksheet (C) (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense percentage increases, project commencement of operation date, etc.).

39. Explain any projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of the Hospital and GWHN.

40. Please describe any anticipated change to existing reimbursement contracts with payers (e.g., Medicare, Medicaid, commercial) as a result of the Asset Purchase. Is it assumed in the financial projections that Applicants will willingly negotiate with the payers that GWHN currently has contracts with?

41. Please explain in detail how the proposed Asset Purchase will be able to assure satisfaction of GWHN and/or the Hospital's debt and pension obligations.

42. Please address the following regarding staffing at the Hospital by completing "Staffing Attachments I&II."

a. Provide the levels of staffing for fiscal year ("FY") 2015 broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the Hospital;

ii. The same information as provided in subsection (a)(i) above showing the RN to patient ratio only; and

iii. The average nursing hours per patient day (NHpPD) for each department and/or unit of the Hospital (all nursing staff should be included in the calculation of nursing hours).

b. Provide the projected levels of staffing by department and/or unit for the Hospital for the first three (3) full FYs following approval of the Asset Purchase broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the Hospital; and

ii. The same information as provided in subsection (b)(i) above showing the projected RN to patient ratio only.

43. For the Hospital, provide a detailed explanation by department and/or unit as completed by the Applicants in Staffing Attachment I, to reconcile any differences between FY 2015 nursing staff levels and those projected for the first three (3) full FYs following approval of the Asset Purchase.

44. For the Hospital, describe any other hospital-employed or hospital-contracted staff besides nursing staff (e.g., hospitalists, mid-level providers, therapists, etc.) that were engaged to provide direct patient care at the hospital (collectively, "Ancillary Caregivers") for FY 2015 broken out as follows:

    a. The type of Ancillary Caregivers and the department and/or unit to which such staff was assigned;

    b. The average number of hours per week that such Ancillary Caregivers provided patient care for the department and/or unit; and

    c. For the first three (3) full FYs following approval of the Asset Purchase, the average number of hours per week that such Ancillary Caregivers are projected to provide patient care for each department and/or unit of the hospital described in subsection (a) above.

45. For the Hospital, provide a detailed explanation by department and/or unit to reconcile any differences between the average number of hours per week that the Ancillary Caregivers described in Question 44 above provided patient care in FY 2015 with those projected for the first three (3) full FYs following approval of the Asset Purchase.

46. For the Hospital, provide evidence that the proposed staffing for nursing staff and Ancillary Caregivers for the first three (3) full FYs following approval of the Asset Purchase meet all Connecticut Department of Public Health ("DPH") staffing requirements and assure continued access to high quality and affordable health care. Be sure to cite the appropriate DPH regulations and/or other industry benchmarks as applicable.

47. Applicants are required to provide copies of the most recent CMS statements of deficiencies and plans of correction (CMS Form 2567) for all hospitals owned by PMH. Provide these documents in an electronic format only, PDF file on a CD to accompany the responses. No paper copies required.

48. Provide a copy of, and describe any changes to, any of the following policies and procedures that will be in place at the Hospital if the Asset Purchase is approved:

    a. Hospital collection policies (including charity care and bad debt);

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

c. the annual or periodic market rate assessment for the Hospital.

49. The Hospital has provided OHCA with their annual FY 2015 pricemasters, which were most recently updated for the month of June 2015. With respect to this submission please answer the following:

a. Will the pricemaster change as a result of the Asset Purchase?

b. If so, please identify any anticipated increases or decreases to the pricemaster as a result of the Asset Purchase.

c. Please quantify the overall percentage increase or decrease in the pricemaster that is anticipated in subsection (b) above and explain the rationale for such change.

50. Please provide monthly financial statistics reports for the months of April, May and June FY 2015, current month and year-to-date, and comparable period for FY 2014 to OHCA, for the Hospital only, GHWN and PMH with the Application and thereafter on a monthly basis for each month (formatted side by side), until a public hearing in this matter is held. The following financial measurements/indicators should be addressed in the reports:

Monthly Financial Measurement/Indicators

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

Cash and Cash Equivalents
Net working Capital
Unrestricted Assets
Credit Ratings (S&P, FITCH and Moody's)

51. For the Hospital, provide a copy of its IRS Form 990 for the for tax year ending September 30, 2014 and with respect to the amounts listed on each line item within Part 1, Section 7 of Schedule H ("Financial Assistance and Certain Other Community Benefits at Cost"), provide a projected amount for each line item for the first three (3) tax years following the Asset Purchase. Please note that it is understood that the Hospital will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the Hospital will continue to provide in these community benefit categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to GWHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as GWHN's current policies.

52. For the Hospital, with respect to the amounts listed on each line item within Part II of Schedule H of the Hospital's IRS Form 990 for tax year ending September 30, 2014 ("Community Building Activities"), provide a projected amount for each line item for the first three (3) tax years following the Asset Purchase. Please note that it is understood that the Hospital will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the Hospital will continue to provide in these community building activity categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to GWHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as GWHN's current policies.

53. Please discuss whether the Asset Purchase is expected to achieve an improved negotiating position with vendors and/or payers and, if such an improved negotiating position is anticipated, how it will translate into tangible savings for the consumer of health care services. Provide a response that both describes any anticipated improvements in detail and quantifies the expected results for the consumer.

54. Provide details of plans to be put in place to ensure the proposed health care services provided by PMH adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (For more details on CLAS standards see http://minorityhealth.hhs.gov/Default.aspx#sthash.U320zUXq.dpuf.)

55. What criteria will PMH use to offer current employees employment post transaction or in any new entities that may be formed as a result of this proposal? For those

employees that will be employed post transaction by the Applicants, what is the projected difference in salary for current employees and similarly situated employees at other hospitals operated by PMH in similar markets?

56. Please provide information regarding whether any health care providers or insurers have an ownership interest in PMH.

57. Please provide information on the relationship, if any, that PMH's existing medical group segment will have to this proposal.

58. Please identify PMH's five (5) most recent acute care hospital acquisitions and, for each acquisition, describe in detail how:

    (a) the acquisition improved access to care for the hospital's service area;

    (b) the acquisition improved the quality of health care for the hospital's service area;

    (c) the acquisition lowered the cost of health care for the hospital's service area; and

    (d) with respect to subsections (a) through (c) above, please demonstrate these improvements/cost reductions through benchmarks and other data that are commonly used in the hospital industry.

After receipt of your application for approval, the Commissioner and the Attorney General shall review the submission to determine whether the application for approval is complete. If not, the Commissioner and the Attorney General shall provide written notice of any deficiencies within twenty (20) days of receipt of the application for approval.

Should you have any questions regarding this application form, your application for approval, or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Perry Zinn Rowthorn
Deputy Attorney General

Janet M. Brancifort
Janet M. Brancifort, MPH
Deputy Commissioner, DPH

Attachments

cc: Steven W. Lazarus, Associate Health Care Analyst, OHCA
Gary W. Hawes, Assistant Attorney General, OAG

Staffing Attachment I

Name of Hospital Unit or Department	Current Staffing Levels: Average Nurse to Patient Ratio – Shift #1 AM	Shift #2 PM	Shift #3 overnight	Current Staffing Levels: Average RN to Patient Ratio – Shift #1 AM	Shift #2 PM	Shift #3 overnight	Average Nursing Hours per Patient Day
Department or Unit Name	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	0.00
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Staffing Attachment II

Name of Hospital Unit or Department	Projected Staffing Levels FY 201x						Projected Staffing Levels FY 201x						Projected Staffing Levels FY 201x					
	Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nurse to Patient Ratio			Average RN to Patient Ratio		
	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight
Department or Unit Name	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx
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CARMODY

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Ann H. Zucker
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azucker@carmodylaw.com

707 Summer Street
Stamford, CT 06901

October 2, 2015

VIA FEDEX AND EMAIL (kevin.hansted@ct.gov; gary.hawes@ct.gov)

Attorney General George Jepsen
Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120

Commissioner Jewel Mullen, MD, MPH, MPA
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Greater Waterbury Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31217-486 and Attorney General Docket No. 15-486-02

Dear Mr. Jepsen and Dr. Mullen:

On behalf of Greater Waterbury Health Network, Inc. in connection with the above referenced matters, we hereby submit a request for an extension to the sixty (60) day time period set forth in Conn. Gen. Stat. §19a-486a(e) to the above referenced matters in the application for approval of the proposed asset purchase.

We are hereby requesting a thirty (30) day extension to this application submission deadline to fully complete and assemble the information required. Prospect Medical Holdings, Inc. joins in on this request and will be simultaneously submitting the same extension request.

If you have any questions or require anything further, please contact me at 203-252-2652. Thank you for your assistance in this matter.

Very truly yours,

Ann H. Zucker

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Gary Hawes, Associate Attorney General, Office of the Attorney General
Jonathan Spees, Prospect Medical Holdings, Inc.
Michele M. Volpe, Bershtein, Volpe & McKeon, P.C.

Greer, Leslie

From: Martone, Kim
Sent: Friday, October 02, 2015 3:35 PM
To: Greer, Leslie
Subject: FW: GWHN - Response to Extension Request
Attachments: 2015-10-02 GWHN - Response to Extension Request.pdf

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From: Hawes, Gary W.
Sent: Friday, October 02, 2015 3:32 PM
To: Ann H. Zucker (azucker@carmodylaw.com); mmv@bvmlaw.com
Cc: Martone, Kim; Lazarus, Steven; Zinn-Rowthorn, Perry A.; Salton, Henry A.
Subject: GWHN - Response to Extension Request

Ann and Michele,

Please see the attached response to the request for an extension of time.

Gary

Gary W. Hawes | Assistant Attorney General | Office of the Attorney General
55 Elm Street | P.O. Box 120 | Hartford Connecticut 06106
T: 860.808.5020 | F: 860.808.5347 | gary.hawes@ct.gov

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF THE ATTORNEY GENERAL

GEORGE JEPSEN
ATTORNEY GENERAL

DR. JEWEL MULLEN
COMMISSIONER

October 2, 2015

Ann H. Zucker, Esq
Carmody & Torrance LLP
195 Church Street, P.O. Box 1950
New Haven, Connecticut 06509-1950

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.
105 Court Street, Third Floor
New Haven, Connecticut 06511

Re: Greater Waterbury Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-32017-486 and AG Docket No. 15-486-02

Dear Attorney Zucker and Attorney Volpe:

Thank you for your letter dated October 1, 2015, pursuant to which you have requested a 30-day extension of the 60-day time period set forth in Conn. Gen. Stat. § 19a-486a(e) for the filing the Application for approval of the proposed asset purchase by Prospect Medical Holdings, Inc., of Greater Waterbury Health Network, Inc.

Our Offices agree to extend the Application time period as you have requested and as set forth above. The 60-day time period was due to expire on October 5, 2015. With the 30-day extension, the due date for the Application will now be November 4, 2015.

Should you have any questions regarding this extension, your Application for approval, or any other issues relating to the Commissioner's and the Attorney General's review, please do not hesitate to contact either Steven Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant

Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General
Office of the Attorney General

Very truly yours,

Kimberly Martone
Director of Operations
Office of Health Care Access
Department of Public Health

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Ann H. Zucker
Partner
Direct: 203-252-2693
Fax: 203-325-8608
azucker@carmodylaw.com

707 Summer Street
Stamford, CT 06901-1026

October 28, 2015

VIA HAND DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120
Attn: Gary W. Hawes, AAG

Commissioner of Public Health
410 Capitol Avenue
Hartford, CT 06134
Attn: Kevin Hansted, Staff Attorney

Re: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. – Certificate of Need Application for Proposed Asset Purchase – OHCA Docket No. 15-31217-486 and Attorney General Docket No. 15-486-02

Dear Messrs. Hawes and Hansted:

Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. hereby submit an application for approval of a Certificate of Need for the proposed asset purchase (the "Application"). At your request, two copies have been hand delivered to Mr. Hawes' office and one copy has been hand delivered to Mr. Hansted' office. In addition, Mr. Hawes' office has received two electronic versions and Mr. Hansted's office has received an electronic version on a USB flash drive as requested.

Please note that Exhibit Q11-2 of the Application is being bulk filed and therefore only one copy has been provided to Mr. Hawes' office. Exhibit 11-2 contains information on Waterbury Hospital's restricted funds. Exhibit 11-2 has also been scanned to electronic format for your review. If further hard copies are required, please let me know.

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

If you have any questions or need anything further, please contact me at (203) 252-2693. Thank you for your assistance in this matter.

Very truly yours,

CARMODY TORRANCE SANDAK & HENNESSEY LLP

By _____
Ann H. Zucker

BERSHTEIN VOLPE & McKEON, P.C.

By _____
Michele M. Volpe

AHZ:rk
Enclosures

cc: Jonathan Spees, Prospect Medical Holdings, Inc.
Darlene Stromstad, Greater Waterbury Health Network, Inc.

Application Checklist

Instructions:

1. Complete the following checklist and **submit** as the first page of the CON application:

☒ Attached is a paginated hard copy of the CON application (all social security numbers must be redacted), including a completed affidavit, signed and notarized by the appropriate individuals.

☒ *(*New*).* A completed supplemental application form specific to the proposal type, available on OHCA's website under OHCA Forms (see previous page for the list of supplemental forms).

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

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

☒ Attached is a completed Financial Worksheet (A, B or C) available at OHCA's website under OHCA Forms.

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

☒ The following have been submitted on a USB flash drive:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format; and
2. An electronic copy of the completed application forms in **MS Word** (the applications) and **MS Excel** (Financial Worksheet)

For OHCA Use Only:

Docket No.: 15-32017-486 **Check No.:** 1490743
OHCA Verified by: SCJ **Date:** 10/29/15

OFFICIAL CHECK

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

WebsterBank®

OFFICIAL CHECK

0001490743

51-7010
2111

145 Bank St
Waterbury, CT 06702

00017 978218

10/27/2015

********$500.00

PAY TO THE ORDER OF

500 DOLLARS AND 00 CENTS

TREASURER - STATE OF CT

AUTHORIZED SIGNATURE

REMITTER CTSH - WHN

AUTHORIZED SIGNATURE (TWO SIGNATURES REQUIRED OVER $25,000)

⑈0001490743⑈

AFFIDAVIT

Applicant: Greater Waterbury Health Network, Inc.

Project Title: Greater Waterbury Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OCHA Docket No. 15-31217-486 and Attorney General Docket No. 15-486-02

I, Darlene Stromstad, FACHE, President/CEO of Greater Waterbury Health Network, Inc. being duly sworn, depose and state that Greater Waterbury Health Network, Inc.'s information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 10/19/15
Date

Subscribed and sworn to before me on October 19, 2015

Notary Public / Commissioner of the Superior Court

My commission expires: 7-31-16

{W2596904}

Affidavit

Applicant: Prospect Medical Holdings, Inc.

Project Title: Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Sam Lee (Name), CEO (Position – CEO or CFO)

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

Signature 10/16/2015 Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

F/s. see attached.

JURAT

A notary public or other officer completing this Certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on
this 16th day of OCTOBER, 2015,

by * * * SANG BUM LEE * * * * * * * * *
proved to me on the basis of satisfactory evidence to
be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

Signature E. Lucas (Seal)

Legals/ Public Notices

INVITATION TO BID

MAIN STREET REALIGNMENT AND STREETSCAPE IMPROVEMENTS - PHASE IB
BID # 0458-027-080725

Sealed bids are invited and will be received by the City of Torrington, at the office of the City Purchasing Agent, City Hall, 140 Main Street, Room 206, Torrington, Connecticut (until) 11:00 A.M., August 7, 2015 at which time and place they will be publicly opened and read aloud, in the event of the closure of City Hall, the bid will be opened at 11:00 A.M on the following business day that City Hall is opened. Each bid must be submitted on the forms provided and in a sealed envelope bearing on the outside, the name of the bidder, his address, and the name of the project for which the bid is submitted, bid number and bid opening date/time clearly identified on the outside of the envelope/package. A bid bond in an amount not less than five percent (5%) of the amount of the bid shall accompany each bid. A non-collusion statement for Prime Contractors and any addendum acknowledgement must also be submitted at the time of the bid.

The scope of the work includes furnishing all equipment, labor, material, plant, and supervision/area to perform all work necessary for the construction of streetscape improvements that includes new concrete sidewalks, granite curb, landscaping, lighting, drainage structures, paving, and relocation/new infrastructure work. This work also includes demolition of existing sidewalk, curbs, and streetscape items.

This project will have a Disadvantaged Business Enterprise (DBE) goal of no less than zero percent (0%) of the construction contract value.

Attention of bidders is directed to certain requirements of this contract which require payment of Davis-Bacon wages, and compliance with certain local, state and federal requirements. Contractors should be aware of special "Buy American" compliance and reporting requirements.

The information for Bidders, Form of Bid, Specifications, and other Contract Documents may be obtained or examined at the Office of the City Purchasing Agent, Rm 206, City Hall, 140 Main Street, Torrington, Connecticut 06790, during normal office hours (M. - W. 8:30 a.m. – 4:30 p.m., Th. 8:30 a.m. - 8:30 p.m., F. 8:30 a.m. - 12:30 p.m.). A $50.00 non-refundable fee for bid documents, payable to the City of Torrington, will be required of all prospective bidders.

Bids to receive consideration, must be in the hands of the authorized representative, no later than the day and hour mentioned above. Any bid received after the date and time specified will be rejected. The City of Torrington reserves the right to accept or reject any or all bids, to waive technicalities, or, to award the contract to a bidder other than the lowest bid, and to award the contract as it feels will best serve the public interest.

All bids will be considered valid for a period of sixty (60) days.

Pennie Zucco
Purchasing Agent
Dated: July 17, 2015

An Affirmative Action/ Equal Opportunity Employer
R-A July 18, 2015

LEGAL NOTICE
FORECLOSURE ACTION SALE
PNC Bank, National Association
vs
John E. Mahoney, ET AL
DOCKET NO: LLI-CV14-6011322-S
PROPERTY ADDRESS: 404 Farmington River Turnpike, New Hartford, CT
PROPERTY TYPE: RESIDENTIAL
DATE OF SALE: JULY 25, 2015
COMMITTEE NAME: JUDITH DUGON
COMMITTEE PHONE NUMBER (860) 378-7830
See Foreclosure Sales at www.jud.ct.gov for more detailed information
R-A June13 & 20, 2015

Classified is convenient! One quick call sells it all! (203) 574-3616

Republican-American Classifieds

INVITATION TO BID

Proposals are invited by the owners for rehabilitation work on the property specified below:
Project Address: 1325 Norfolk Road
Torrington CT 06790
Proposals will be received until 9:00 a.m. on Wednesday, August 5, 2015 at which time they will be opened. Proposals will be delivered to:
City of Torrington
Purchasing Department Office
140 Main Street
Torrington CT 06790
A mandatory pre-bid conference will be held at the following location and time:
1325 Norfolk Road
Torrington CT 06790
Project Specifications (engineered plans) will be available at the pre-bid site.
The above work includes: Masonry retaining wall, stairs, and landings.
For more information, contact Bob Cataldo at phone: 203-573-1188 x 211 or email bob@wagnerassociates.com
AN AFFIRMATIVE ACTION / EQUAL OPPORTUNITY EMPLOYER
MBE / WBE / SBE AND SECTION 3 DESIGNATED CONTRACTORS ARE ENCOURAGED TO APPLY

REQUEST FOR PROPOSAL
Septic System Ground Water Drainage Design and Related Services
The owner of the property located at 1325 Norfolk Road, Torrington CT 06790, is requesting a proposal from qualified firms or individuals for the design of an engineered ground water drainage system for the existing septic system, for a single family home, and related construction observation services.
Interested parties should submit their proposal including a statement of their qualifications and experience to the City of Torrington, Purchasing Department's Office, 140 Main Street, Torrington CT 06790, no later than 9:00 a.m. on Wednesday, August 5, 2015.
Proposals must include the following:
1. Statement of the firm's qualifications and experience with projects of this type including names and resumes of individuals to be assigned to the project.
2. Identify any sub-contractors/consultants to be used and their responsibility as to the project design and completion of work and coordination between disciplines should be detailed.
3. Insurance certificate with general liability, workmens compensation, and errors and omissions.
4. Fee proposal for topographic survey, existing conditions map, establishing benchmarks, an A-2 survey, system design, additional soil testing if required and local and/or State approvals as required for plan approvals, attendance of pre-construction meeting, construction observations, presentation of as built, and construction closeout.
5. Approval of design by the local Health District and submittal of 12 copies of plans and specification, after approval of Health district.
6. A proposed time schedule for completion of the total project broken down by phases.
7. Cost for each work item listed above. No percentage of cost proposals will be accepted.
There will be a pre-proposal meeting on site at 1325 Norfolk Road, Torrington CT 06790, on Wednesday, July 29, 2015 at 8:30 a.m., for interested parties to view the site and existing conditions.
For any questions or additional information, please contact Bob Cataldo at 203-573-1188, Ext. 211, Monday through Friday, from 8:30 a.m. to 4:30 p.m. Or email bob@wagnerassociates.com.
An Affirmative Action/Equal Opportunity Employer
MBE/WBE/SBE and Section 3 Designated Contractors are encouraged to apply

R-A June 18, 2015

Advertise in the classifieds and really clean up! Your unwanted items could be in big demand!

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket No. LLI-CV 15-6011726 S
In Bremaster of FAIRFIELD
BANK v. STEVENSON, MATTHEW, ET AL.
Property Address: 143 Proposed Mountain Road, Litchfield, CT
Property Type: 7 room, 4 BR, 3.5 B Single family residence on approx 1 1.82 acres having approximately 4,932 SF of living area
Date of Sale: Saturday, August 1, 2015 at 12:00 Noon on the premises
Committee Name:
ATTORNEY THOMAS P. MC-DERMOTT, JR.
21 Beach Street, P.O. Box 3044
Litchfield, CT 06759
Committee Phone Number: (860) 567-9166
See Foreclosure Sales at http://www.jud.ct.gov/ for more detailed information

R-A July 18 & 25, 2015

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO:
LLI-CV14-6010153-S

CASE NAME:
U.S. Bank National Association, as Trustee
v.
Holly Ransom, et al

PROPERTY ADDRESS:
168 Hopbrook Road,
West Hartland, CT

PROPERTY TYPE:
Residential

DATE OF SALE:
July 25, 2015,
at 12:00 noon on premises

COMMITTEE NAME:
Robert F. Dwyer, Jr.
Law Offices of
Robert F. Dwyer, Jr., LLC
140 Willow St., Suite 4H
Winsted, CT 06098

COMMITTEE PHONE NUMBER:
1-860-379-7560

See Foreclosure Sales @ www.jud.ct.gov
for more detailed information
RA July 11 & 18 2015

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO.:
LLI CV14-6011473-S

CASE NAME:
James B. Nutter
v.
Roslyn Pilewski, et al

PROPERTY ADDRESS:
32 Slaughterhouse Road,
Washington, CT

PROPERTY TYPE:
RESIDENTIAL

DATE OF SALE:
SATURDAY, August 1, 2015
at 12:00 NOON

COMMITTEE NAME:
J. MICHAEL SCOWNERS, Esq.

COMMITTEE PHONE NUMBER:
860-567-0828

See Foreclosure Sales at www.jud.ct.gov for more detailed information.
R-A July 18 & 25, 2015

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO:
LLI-CV14-6011310-S

CASE NAME:
Connecticut Housing Finance Authority
vs.
Kevin J. Bishop, et al

PROPERTY ADDRESS:
54 Lincoln Avenue,
Torrington, CT 06790

PROPERTY TYPE:
Residential Colonial

DATE OF SALE:
August 1, 2015

COMMITTEE NAME:
Gerald R. Role, Esq.

COMMITTEE PHONE NUMBER:
860-482-3473

See Foreclosure Sales at www.jud.ct.gov
for more detailed information
R-A July 18 & 25, 2015

LEGAL NOTICE
FORECLOSURE AUCTION SALE

CASE NAME:
Wilmington Savings Fund Society, FSB, Doing Business as Christiana Trust, Not in its Individual Capacity But Solely As Legal Title Trustee for Bronze Creek Title Trust 2013-NPL1
v.
Christopher A. Fisher ET AL.

PROPERTY ADDRESS:
59 Elmira Avenue
Torrington, CT

PROPERTY TYPE:
Residential

DATE OF SALE:
Saturday, August 1, 2015
at 12:00 noon

COMMITTEE NAME:
Attys. Fillichio & F. Magistrelli

COMMITTEE TELEPHONE NO:
860-626-0777

See Foreclosure Sales at www.jud.ct.gov
for more detailed information
R-A July 18 & 25, 2015

LEGAL NOTICE
ORDER OF NOTICE
STATE OF CONNECTICUT
SUPERIOR COURT
J.D. OF FAIRFIELD
AT BRIDGEPORT
JULY 13, 2015

DOCKET NO. FBT-CV15-6056103-S

MTAG SERVICES, LLC,
AS CUSTODIAN
VS
RPB, LLC, ET AL.
(1559-1567 East Main St., Bridgeport)

NOTICE TO: Fairbank Mortgage Corporation, now or lately known.

Upon the complaint of the plaintiff in the above-entitled action, praying for reasons therein set forth, for a foreclosure of the Mortgage on the premises known as
1559-1563 East Main Street, Bridgeport

and possession of said premises, returnable to the above court on August 25, 2015, and upon a motion for said action for an order of notice, it appearing to and being found by the subscribing authority, that the identities and addresses of the defendant named above are unknown to the PLAINTIFF, and that notice of the institution of this action must likely to come to their attention is that hereinafter ordered: It is

ORDERED, that notice of the institution of this action be given to the said defendant by some proper officer or other person causing a true and attested copy of this order of notice to be published in the Waterbury Republican American, a newspaper of general circulation in the Waterbury, Connecticut area, once a week for two successive weeks, commencing on or before July 27, 2015, and that return of such notice be made to the above-named court.

Judge: Alfred J. Jennings
Processed by Dean Pulos
Judicial District of Fairfield at Bridgeport
RA-JULY 14 & 21, 2015

LIQUOR PERMIT
NOTICE OF APPLICATION
This is to give notice that I, DENNIS I. DEMELLIS
65 HIPP RD
NEW MILFORD, CT
06776-2222
Have filed an application dis-patched 07/17/2015 with the Department of Consumer Protection for a RESTAURANT LIQUOR PERMIT for the sale of alcoholic on the premises at:
693 Main street
WOODBURY, CT 06798-3702
The business will be owned by: CAFE ON 693 MAIN LLC
Entertainment will consist of: NONE
Objections must be filed by: August 28, 2015
DENNIS I. DEMELLIS
RA July 18 & 25, 2015

LEGAL NOTICE
NOTICE TO CREDITORS

ESTATE OF Elaine Barbina, AKA Elaine L. Barbina (15-00478)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury, Probate District, by decree dated July 15, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Thomas P. Brunnock,
Judge

ATTY. Bar No.
c/o Atty David L. Stam, Olcott, Richardson & Stam LLC, 29 Sherman Hill Rd, Woodbury, CT 06798

R-A 7/18/15

PROSPECT PLANNING & ZONING COMMISSION NOTICE OF DECISION

The following action was taken at a regular meeting of the Prospect Planning and Zoning Commission held on Wednesday, July 15, 2015:
APPROVED: Application from Robert Skrla, 108 Cheshire Road for a text change amendment to Prospect's Zoning Regulations Section 2.1, Uses by District to add "Business Office" as a permitted use within the Business District (B) and by Special Permit in the Industrial 1 District (IND-1) and set an effective date of August 15, 2015. Zoning Regulations Questions or concerns on the above decision may be directed to the Land Use Office in the Prospect Town Hall, 36 Center Street, Prospect.
E. Gil Gravelle, Chairman
RA 7/18/2015

TOWN OF SHARON
PO Box 385, 63 Main Street
Sharon, CT 06069

SHARON HISTORIC DISTRICT
LEGAL NOTICE

On Monday, July 27, 2015 at 6:30 PM the Sharon Historic District Commission will hold a public hearing on the following applications for alterations for 28 Roland Road, 72 Main Street and 26 Amenia Union Road. The hearing will be held at Sharon Town Hall, 63 Main Street, Sharon, CT on the second floor.

These applications are on file at the Sharon Land Use Office. At this hearing, interested persons may be heard and written communications received.

Dated this 15th Day of July, 2015.

John Kennedy
Acting Chairman

R-A July 18, 2015

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LEGAL NOTICE

Pursuant to Section 19a-486 of the Connecticut General Statutes (C.G.S."), a nonprofit hospital seeking to transfer a material amount of its assets or operation or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty (30) days after the receipt of the letter.

APPLICANTS
Greater Waterbury Health Network, Inc.
Prospect Medical Holdings, Inc.

TOWN
Waterbury, Connecticut

PROPOSAL
Proposed Transfer of Assets of Greater Waterbury Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

DATE AND TIME
Wednesday, August 5, 2015 at 5:00 p.m.

PLACE:
Courtyard by Marriott
63 Grand Street
Waterbury, Connecticut

PROPOSAL DESCRIPTION

Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH") have submitted a proposal to the State of Connecticut's Office of the Attorney General and Office of Health Care Access, a division of the Department of Public Health for the approval of the transfer of certain of the assets of GWHN and its affiliates to one or more affiliates of PMH.

GWHN, a Connecticut non-stock, 501(c)(3) corporation holds interests in numerous entities, joint ventures and affiliates. GWHN is the parent company of The Waterbury Hospital (the "Hospital"). The Hospital, which was built in 1902, is GWHN's primary asset, and is an acute care facility with 357 licensed beds plus 36 bassinets, located in the heart of Waterbury, Connecticut. The towns served by the Hospital include Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plainville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury ("Service Area").

PMH is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates hospitals, including, but not limited to, Roger Williams Medical Center and Our Lady of Fatima Hospital in Rhode Island. PMH is the parent entity to thirteen (13) acute care and behavioral hospitals located in Rhode Island, Texas and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 300,000 patients in southern California, South Central Texas and Rhode Island through a network of over 9,000 physicians. Through PMH's Coordinated-Regional-Care model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives. Through collaboration, PMH strives to provide every patient with the quality, affordable healthcare they need and deserve.

The estimated total project cost is $100,000,000, which is subject to certain adjustments based on the terms of the transaction documents. The proposed transaction will include the following GWHN entities or their assets:

- The Waterbury Hospital, a licensed general Hospital;
- VNA Health at Home, Inc., a licensed home health care agency;
- Greater Waterbury Management Resources, Inc., management company;
- Greater Waterbury Health Services, Inc.;
- Alliance Medical Group, Inc., a medical foundation;
- Cardiology Associates of Greater Waterbury, LLC, cardiology medical practice;
- Greater Waterbury Imaging Center, LP;
- Access Rehab Centers, LLC;
- Imaging Partners, LLC;
- Waterbury Gastroenterological Co-Management, LLC;
- Harold Leever Regional Cancer Center, Inc.;
- Heart Center of Greater Waterbury, Inc.; and
- Valley Imaging, LLC.

The proposed transaction is subject to a number of approvals including the consent of GWHN joint venture partners in the case of joint ventures. To the extent required, the Applicants will submit separate CON applications relating to the transfers of certain of the assets.

No services changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the Service Area. This proposed transaction will benefit the current employees and communities served by GWHN.

ADDITIONAL INFORMATION

The determination letter is on file with the Office of the Connecticut Attorney General and the Office of Health Care Access.

Articles for sale

COFFEE TABLE & End Table exc. cond. glass tops, with black iron base on both. $100 Call 203-805-4853

COMFORTER Sale Shabby queen, white, excellent condition $20. 203-528-7588

COUCH & LOVESEAT OFF-WHITE w/ 4 matching pillows, open back style, olive green silk covers. New pics. $700. 203-695-9853

DINING ROOM Mahogany table, Lazy Boy Queen sofa bed $400/best. 203-736-2229

DISHWASHER, Kitchenaid like-new stainless $150.00 pic. plus serving pcs. 203-217-3676

DRAFTING TBL $75 Belmont Inclined steerner $75 2 seats drama book $100 203-757-6948

DUVET Queen White 600 thread count Egyptian cotton exc. cond. $80. 203-525-7580

EXHAUST FAN Broan 30" kitchen range exhaust fan $45. 203-894-2253

FISH TANK (10 GAL) w/stand $30; pink bike $45; wood shelf cabinet $45 860-283-0658.

FISH TANK 45 gallons stand, pump, lighted hood and accessories, complete set up. $130 860-283-0882

GAS STOVE Hotpoint, Black-never used. $400/or best offer. Call 203-885-1555

GENERATOR GENERAC New in crate, natural gas/propane. Pd. $2400/asking $1,200. 203-217-2988

GLIDER CHAIR w/ ottoman, tan, good cond. $35; Computer desk, 50"x28" $35; exc cond. 203 217-6963

GOLF CLUBS great beginner's set $25. 5,7,9 & 45. 878-479-1880

HOSPITAL BED By Rimsaano 7 years old $500/ Best 860 945-9431

HOUSEHOLD Brand new starting at $5: New vanity $65, Girls clothes newborn to size 14-16-18-3, Little Tikes (washer, dryer, kitchen and trikes) $35 each 203-217-5153

HYDRATUFA PLANTERS make your own $25; "Race-Master" Projector $75. 203-558-0782

KITCHEN TABLE w/2 chairs $30, Dresser $20; Coffee Table $25. 203-416-4089

KNITTING/SWEATER MACHINE w/ attachments & book $150/best; Army Surplus Sleeping Bag $25. 203-217-2576

LIVE ROCK some corals, about 40 lbs in salt water, plus some fish, $90; 203-206-2424

MAGGS PEVEY PA $300, FENDER BASE PRACTICE AMP $25, SONY TV $10. 860-567-3769

PA SYS 100 watts 3ED 2-Speakers w/stands $400 Bowling bag $15. 230-574-0724

PAINTING Large 47"x47" English cottage in wooden frame, exc. cond $75. 203-758-5788

POWER AMP Dynamic TM Tube II w/Ext. Soker 2-channel for bass/guitar $225 230-574-0774

RAZORS Big Box of Razors, Quality Bulk Razor Blades, www.bigboxofrazors.com

RIDING LAWN MOWER by White Rapper Includes $800. 203-841-8006.

SNEAKERS Lady's Sneakers New Balance size 9.5; never worn; new $70. 860-384-1183

SOFA BED 69" tan w/small flowers $250, good cond. 6-drawer dresser 55" w/mirror, exc cond, $40; 203-317-0586

SOFA & RECLINER (New England Carved) dark blue fabric; sofa & long reclining feature at each end; brass & pet free environment; great condition $400 for both. Call 212-5181 anytime; 203-879-5005 after 6pm, weekends anytime weekends.

SOFA (SECTION A1) with sleeper sofa, tan $100. 203-217-8948

STEGGLE Counter stools 30" Pottery Barn like new $75 each. 203-794-2263

TABLE Ironman Portable / Foldable Massage Table $50. Solid Oak Rocking Horse $15. Hayla Baby Plush Interactive Ride on Pinto Horse w/Sound $30. Louisville Slugger T Ee. Fake Ice Skating Rink w/Carry Bag $30. Metallic & Deep Large Plush Stand Up Zebra $15. Easy Walker Dual Outlet Double Stroller $150. Reasonable Offers Considered. Call 203-710-6719 Leave Message

TOY TRUCKS American Flyer 30's era, 4 buses inks, bids & switchbirds. $100 203-879-0899

VYONA SHRUB TRIM $3 per piece. Proceeds go to "ARK DOG HAVENS" 203-417-6400

WALKER with seat and hand brake, new, $200; 203-641-0800

WASHER & DRYER Kenmore & Maytag heavy duty excellent cond. $200/both 203-910-3681

WASHER OR DRYER front load pedestal drawer $80; Harmony keyboard stand w/stand $30. call Ann (203)206-0307

WATER RESCUE DEVICE condition new, 203-734-2471

WEIGHT SET 2 bars, 2 dumbbells & assorted weights $30/incl. 203-879-7224

WREATH Floral Pine roses w/white lights, beautiful only $80.00. Call 203-796-9785

Bicycles

BICYCLE Girl's Huffy Bike like new 26" tire height, hand

Tag/estate sales

BARN SAUNTER 76 Watkins Hill Rd (r. 8, Exit 7/25 - Sun 7/26 9a-3p. MOVING SALE Books & Household For Info 860 378-3206

KITCHFIELD County Auctions HUGE TAG SALE & AUCTION Fri 7/17- Thurs 7/23, 10-5 daily! ANTIQUES & FINE ART, Furniture, Silver, Artwork, 428 Eastern Road (Rte 202) 860-567-4851

MORRIS MOVING ESTATE 6 East Morris Line, (OFF RTE 109) Fri. 17, Sat. 18 & Sun. 19, 8a-4p. 50 years of accumulation of items.

MORRISTOWN 135 Manners Ave. Sat. 8-3, Huge gar. sale many various items. Rain or Shine.

NAUGATUCK RESIDENTIAL MOVING TAG SALE Everything Must Go! Fri 1st 9am July 17- Fri Back-4pm, Unit to sell!

PROSPECT - 38 Clark Hill Rd. Sat-Sun 10-4pm. FOR WELLO STRAYS.

SANDY HOOK Packrat!! 48 yrs accum! Furn, Housewares, Kitchen Baby Grand, tools, generator, much more! www.antiquemoverman.com for photos/info. Fri 7/17, Sat 7/18, Sun 7/19- 9 am - 1 pm. 7 Gabbett Rd

WATERBURY 549 Frost Rd. Estate Sale, Sun 9-4. Kitchen furn., collectibles and more!

Waterbury Neighborhood
Sat. July 18 & Sun July 19, 9am-4:30pm
Rain date July 25 & 26
William St, Fairview St, Southworth St, more at WaterburyNeighborhood.com

WATERTOWN 116 Artillery Rd. (off Middlebury Rd.) Sat. & Sun. 10-2 Woodbearing Home. MORE!

WATERTOWN Multi-Family Sale 61 Birch Meadow Dr. Sat & Sun July 18-19, 8am-3pm. Furniture, tools, lawn care & more!

Wanted to buy

A BETTER PRICE coins, jewelry diamonds, stamps, silver, dental, estates purchased / auctioned for over 30 yrs auctioneer Tim Champlin 860-459-4864 timsauction.com

ACCORDIONS advertising, all antiques, radio, lamps, guitars, musical inst. and toys, watches, jewelry, Hamilton 860-707-4556

ACCORDIONS ALL GUITARS BRASS musical instruments. Cash paid and I come to you. 860-485-1138.

Antiques/Collectibles/Old Items wtd., all types, from one piece to entire estate. Call about anything! 203-488-8828

MACHINIST TOOLS and TOOLING CARBIDE INSERTS, MECHANIC TOOLS, 860-589-5769

WANTED Diabetic Test Strips, Easy used. Will pick up. Call Don 860-733-8234

Wearing apparel

MEN'S WORK SHOES Thorogood, size 10 1/2 EW, new in box $35/best. 203-879-3127

Wood & fuel

FIREWOOD Seasoned, Cut, & Split. $250/cord. 203-232-6342

Pets & Animals

Accessories/Services
Household Pets
Livestock

Household pets

LONG HAIR CHIHUAHUA PUPPIES 4 males, 2 females ACA reg. Vet checked. $700 860-918-8062

ROTWEILER 2 PUPPIES males, 11 weeks old, AKC reg. Vet checked. $1000. 860-416-8042.

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

CAT Spayed with shots, 4 years old, no dogs/kids, 203-232-0157 leave message

FREE 10 good home, Labrador Retriever 4yrs. Good with kids. Moving, 203-982-4490

RABBITS Free to good home. 203-264-5200

Lost & found

FOUND CATS between Bakewell & Sylvan Ave., Waterbury. Call to describe 203-754-9265

FOUND DOG Farmers Ferry Rd. Watertown on West morning 7/15. Call to describe: 203-232-6319

FOUND Maltese, White Black, all

Legals/ Public Notices

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO:
UWY-CV-13-6022104-S

CASE NAME:
Ciplomortgage, Inc.
vs.
Richard Tiernis, et al

PROPERTY ADDRESS:
14 Devonshire Road,
Wolcott, CT

PROPERTY TYPE:
Residential

DATE OF SALE:
July 25, 2015

COMMITTEE NAME:
Attorney Mark Iannone
250 Wolcott Road
Wolcott, CT 06716

COMMITTEE PHONE#:
203-879-1431

See Foreclosure Sales at:
www.jud.ct.gov
for more detailed information
R-A Jul 12 & 19, 2015

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket No:
UWY-CV-14-6025402-S
Case Name:
Bank of America, National Association vs. Wilfredo AMIAN, ET AL
Property Address:
44-46 Cherry Street, Waterbury, CT
Property Type:
Residential
Date of Sale:
Saturday, August 1, 2015 at 12:00 Noon
Committee Name:
Attorney Linda N. Mayo
R-A 7/18/15 & 7/26/15

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket No:
UWY-CV13-6014968-S
Case Name: U.S. Bank National Association, as Trustee v. Joseph Dunbar, Sr. A/K/A Joseph Dunbar, et al.
Property Address: 547 Bucks Hill Rd., Waterbury, CT 06704
Property Type: Residential
Date of Sale: August 1, 2015
12:00 noon at the premises
Committee Name:
Russell Shulsky
Committee Phone #:
(203) 729-5117
Deposit: $30,000.00 by bank or certified check only
See Foreclosure Sales at
www.jud.ct.gov for more detailed information.
R-A July 19 & 26, 2015

TOWN OF WOLCOTT
INVITATION TO BID #16-07
SERVER
DO NOT CALL THE WOLCOTT TOWN HALL
REGARDING THIS NOTICE

The Town of Wolcott requests bids from qualified vendors to supply a Server for the Wolcott Town Hall in accordance with specifications contained in this bid package available by email request to Alauriault@wolcottct.org or by fax request to Linda R. Bruce, Municipal Finance Officer at 203-879-8305. Please put "16-07 SERVER" in the subject line of email requests. Sealed bids, including mailing envelopes and/or shipping containers, will be clearly marked "16-07 SERVER", will show the name & address of the bidder, and will be delivered to Linda R. Bruce, Municipal Finance Officer, Wolcott Town Hall, 10 Kenea Ave., Wolcott, CT 06716 by 10:30 A.M., August 4th, 2015. Bids will be opened and read in public immediately following the bid closing time in the Council Chambers, Wolcott Town Hall. The Town of Wolcott reserves the right to reject any and all bids, waive any irregularities, omissions, excess verbiage or technical defects in the bids, and the Town need not necessarily award the contract to the firm submitting the lowest bid. If, in the opinion of the Town, it would be in the best interests of the Town of Wolcott to accept either than the lowest bid because of another firm's greater experience and/or experience.
THE TOWN OF WOLCOTT IS AN EQUAL OPPORTUNITY EMPLOYER
RA-July 19, 2015

Legals/ Public Notices

NOTICE

The U-Haul Moving and Storage Co. of 169 Meriden Rd Waterbury CT 06705 will sell household and personal items that are contained in the storage rooms to pay the unpaid storage fees. 203-754-2073.

Jessica Alexander Rm# 0100
Carolyn Hays Rm# 0025
Melanie Painter Rm# 0404
Jennifer Thompson Rm# 0509
Jarrett Hite Room # 0094
Joseph Longo Room# 0046-18
Lashaun James Room# 3087
Cayetta West Room# 1048
Jerone Harris Room# 3032
Rosa Estela de Rosario AA6281E
Robin Keichel Room# AA6681E

Contents to be sold on the premises of 169 Meriden Rd Waterbury CT 06705 on July 28th 2015 at 11:30 am. Purchases to be paid for in cash or credit card at the time of purchase; also a $100.00 cash deposit will be needed on each room purchased. U-Haul reserves the right to bid or purchase any lot or space. Auction service provided by Storage Solutions www.StorageAuctionSolutions.com

R-A July 19 & 26, 2015

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NUMBER:
UWYCV156026946

CASE NAME:
Live Well Financial, Inc.
vs.
Florina Buscu Longhi et al.

PROPERTY ADDRESS:
15 Rosewood Drive,
Prospect, CT

DATE OF SALE:
Saturday, July 25, 2015
12:00 noon on the premises

DEPOSIT AMOUNT:
$15,000.00
Deposit to be paid by bank or certified check only

COMMITTEE APPOINTED:
Mark Matzevanas
38 Central Ave.,
Waterbury, CT 06702

COMMITTEE PHONE:
203-753-2015

See Foreclosure Sales at:
www.jud.ct.gov
for more detailed information.
R-A July 12 & 19, 2015

Remodel It Right!
Find Help In The
At Your Service Directory
Every Day In The Republican/American Classifieds!

TOWN OF WOLCOTT
REQUEST FOR PROPOSAL #16-06
SERVER
DO NOT CALL THE WOLCOTT TOWN HALL
REGARDING THIS NOTICE

The Town of Wolcott requests bids from qualified vendors to supply a Server for the Wolcott Police Department in accordance with specifications contained in the bid package available by email request to pburns@wolcottct.org or by fax request to Linda R. Bruce, Municipal Finance Officer at 203-879-8305. Please put "RFP#16-06 SERVER" in the subject line of email requests. Sealed bids, including mailing envelopes and/or shipping containers, will be clearly marked "RFP #16-06 SERVER", will show the name & address of the bidder, and will be delivered to Linda R. Bruce, Municipal Finance Officer, Wolcott Town Hall, 10 Kenea Ave., Wolcott, CT 06716 by 11:00 A.M., August 4th, 2015. Bids will be opened and read in public immediately following the bid closing time in the Council Chambers, Wolcott Town Hall. The Town of Wolcott reserves the right to reject any and all bids, waive any irregularities, omissions, excess verbiage or technical defects in the bids, and the Town need not necessarily award the contract to the firm submitting the lowest bid. If, in the opinion of the Town, it would be in the best interests of the Town of Wolcott to accept either than the lowest bid because of another firm's greater experience and/or experience.

THE TOWN OF WOLCOTT IS AN EQUAL OPPORTUNITY EMPLOYER
RA July 19, 2015

Legals/ Public Notices

NOTICE

The U-Haul Storage of Downtown Waterbury, 560 Bank Street, Waterbury, CT will sell household and personal items that are contained in the following storage rooms due to unpaid storage fees.

Joel Cross Rm# 1100
Arthur Davis Rm# 1113
Nelson Craig Rm# 1172
Marlene Melo Rm# 2006
Cindy Cuevas Rm# 2075
Shanequa Hughes Rm# 3114
Alyssa Franklin Rm# 2135
Anthony Rippin Rm# 3019
Samuel Santiago Rm# 3077
Sasha Sanabria Rm# 3138

Contents to be sold on the premises of 560 Bank Street Waterbury, CT 06708, on July 28th, 2015 at 10:00 a.m. Purchases are to be paid for in cash or credit card and a $100.00 cash deposit will be needed on each room purchased. U-Haul reserves the right to bid or purchase any lot or space. Auction service provided by Storage Auction Solutions. www.storageauctionsolutions.com

R-A July 19 & 26, 2015

STATE OF CONNECTICUT
SUPERIOR COURT
JUDICIAL DISTRICT OF LITCHFIELD
AT LITCHFIELD
JUNE 19, 2015
RETURN DATE: AUGUST 18, 2015

URBAN FINANCIAL OF AMERICA, LLC
v.
THE WIDOW, HEIRS AND/OR CREDITORS OF THE ESTATE OF LYDA D. MEYER A/K/A LYDA MEYER, ET AL.

NOTICE TO THE WIDOW, HEIRS AND/OR CREDITORS OF THE ESTATE OF LYDA D. MEYER A/K/A LYDA MEYER AND ALL UNKNOWN PERSONS, CLAIMING OR WHO MAY CLAIM, ANY RIGHTS, TITLE, INTEREST OR ESTATE IN OR LIEN OR ENCUMBRANCE UPON THE PROPERTY DESCRIBED IN THIS COMPLAINT, ADVERSE TO THE PLAINTIFF, WHETHER SUCH CLAIM OR POSSIBLE CLAIM BE VESTED OR CONTINGENT.

The Plaintiff has named as a Defendant, THE WIDOW, HEIRS AND/OR CREDITORS OF THE ESTATE OF LYDA D. MEYER A/K/A LYDA MEYER and all unknown persons, claiming or who may claim, any rights, title, interest or estate in or lien or encumbrance upon the property described in this Complaint, adverse to the Plaintiff, whether such claims or possible claims can be vested or contingent, if not living, as a party defendant(s) in the complaint which it is bringing to the above-named Court seeking a foreclosure of its mortgage upon premises known as 60 Portman Street, Torrington, CT 06790.

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 AND/OR CREDITORS OF THE ESTATE OF LYDA D. MEYER A/K/A LYDA MEYER and all unknown persons, claiming or who may claim, any rights, title, interest or estate in or lien or encumbrance upon the property described in this Complaint, adverse to the Plaintiff, whether such claims or possible claim can be vested or contingent, by some proper officer causing a true and attested copy of this Order of Notice to be published in the Waterbury Republican, once a week for 2 successive weeks, commencing on or before August 3, 2015, and that return of such service be made to this Court.

By the Court,
By: Craig D. Malone
Asst. Clerk

A True Copy Attest:
Michael J. Brown
Connecticut State Marshal
R-A July 19 & 26, 2015

Legals/ Public Notices

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket No.
UWY-CV14-6024201-S
Case Name:
ONEWEST BANK, N.A.
v.
MOFFLER, CLARENCE, ET AL
Property Address:
228-230 Cooke Street,
Waterbury, CT
Property Type: Three-Family Residential Property
Date of Sale: Saturday, August 1, 2015
Committee name:
Edwin C. Mix
Committee Phone Number:
203.729-4248
See Foreclosure Sales at www.jud.ct.gov for more detailed information
R-A July 19, & 26, 2015

Legal Notice

Notice is hereby given that there will be a caucus of all enrolled Democratic electors of the Town of Colebrook on July 27, 2015 at 7 pm at the Colebrook Town Hall Meeting Room, 2nd Floor, 552 Colebrook Road, Colebrook, CT to endorse candidates for the official offices and to transact such other business as may be proper.

Dated at
Colebrook, Connecticut,
this 14th day of July, 2015

Colebrook
Democratic Town Committee
Thomas U. McKeon, Chairman
R-A July 19, 2015

Legals/ Public Notices

LEGAL NOTICE
NOTICE TO:
Alexandra Kanakis,
mother of a male child born on 07/12/2003 to parties unknown.

A petition has been filed seeking the commitment of the above minor child or vesting custody and care of said child of the above named in a lawful, private or public agency or a suitable and worthy person.

The petition, whereby the court's decision can affect your parental rights, if any, regarding the minor child will be heard on 08/12/2015 at 10:00 a.m. at 64 Hal. 7 Kendrick Avenue, Waterbury, CT 06702.
R-A July 19, 2015

Legals/ Public Notices

LEGAL NOTICE
NOTICE TO: Luis Colon
father of a male child born to Alexandra L. on 07/12/2003 of parts unknown.

A petition has been filed seeking commitment of the above minor child or vesting custody and care of said child of the above named in a lawful, private or public agency or a suitable and worthy person.

The petition, whereby the court's decision can affect your parental rights, if any, regarding the minor child will be heard on 08/12/2015 at 10:00 a.m. at 64 Hal. 7 Kendrick Avenue, Waterbury, CT 06702.
R-A July 19, 2015

LEGAL NOTICE

Pursuant to Section 19a-486 of the Connecticut General Statutes ("C.G.S."), a nonprofit hospital seeking to transfer a material amount of its assets or operation or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty (30) days after the receipt of the letter.

APPLICANTS
Greater Waterbury Health Network, Inc.
Prospect Medical Holdings, Inc.

TOWN
Waterbury, Connecticut

PROPOSAL
Proposed Transfer of Assets of Greater Waterbury Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

DATE AND TIME
Wednesday, August 5, 2015 at 5:00 p.m.

PLACE:
Courtyard by Marriott
63 Grand Street
Waterbury, Connecticut

PROPOSAL DESCRIPTION

Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH") have submitted a proposal to the State of Connecticut's Office of the Attorney General and Office of Health Care Access, a division of the Department of Public Health for the approval of the transfer of certain of the assets of GWHN and its affiliates to one or more affiliates of PMH.

GWHN, a Connecticut non-stock, 501(c)(3) corporation holds interests in numerous entities, joint ventures and affiliates. GWHN is the parent company of The Waterbury Hospital (the "Hospital"). The Hospital, which was built in 1902, is GWHN's primary asset, and is an acute care facility with 357 licensed beds plus 36 bassinets, located in the heart of Waterbury, Connecticut. The towns served by the Hospital include Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury ("Service Area").

PMH is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates hospitals, including, but not limited to, Roger Williams Medical Center and Our Lady of Fatima Hospital in Rhode Island. PMH is the parent entity to thirteen (13) acute care and behavioral hospitals located in Rhode Island, Texas and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 300,000 patients in southern California, South Central Texas and Rhode Island through a network of over 9,000 physicians. Through PMH's Coordinated-Regional-Care model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives. Through collaboration, PMH strives to provide every patient with the quality, affordable healthcare they need and deserve.

The estimated total project cost is $100,000,000, which is subject to certain adjustments based on the terms of the transaction documents. The proposed transaction will include the following GWHN entities or their assets:

- The Waterbury Hospital, a licensed general Hospital;
- VNA Health at Home, Inc., a licensed home health care agency;
- Greater Waterbury Management Resources, Inc., management company;
- Greater Waterbury Health Services, Inc.;
- Alliance Medical Group, Inc., a medical foundation;
- Cardiology Associates of Greater Waterbury, LLC, cardiology medical practice;
- Greater Waterbury Imaging Center, LP;
- Access Rehab Centers, LLC;
- Imaging Partners, LLC;
- Waterbury Gastroenterological Co-Management, LLC;
- Harold Leever Regional Cancer Center, Inc.;
- Heart Center of Greater Waterbury, Inc.; and
- Valley Imaging, LLC.

The proposed transaction is subject to a number of approvals including the consent of GWHN joint venture partners in the case of joint ventures. To the extent required, the Applicants will submit separate CON applications relating to the transfers of certain of the assets.

No services changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the Service Area. This proposed transaction will benefit the current employees and communities served by GWHN.

ADDITIONAL INFORMATION

The determination letter is on file with the Office of the Connecticut Attorney General and the Office of Health Care Access.

redplum.com
SmartSource
Look For
Money-Saving Coupons
Every Week In the
SundayRepublican

Wanted to buy

Antiques/Collectibles/Old Items Jewelry, Art, Stamps, Toys, Silver, Gold Coins Call about anything! 203-888-8129

MACHINIST TOOLS AND TOOLING CARBIDE INSERTS, MEASURING TOOLS, 203-385-5700

WANTED Diabetic Test Strips. Cash paid. Will pick up. Call Dan 203 139-5834

Wearing apparel

MEN'S WORK SHOES Thoroughbred, size 10 1/2 EW, new in box $65/best. 203-879-3137

Wood & fuel

FIREWOOD Seasoned. Cut & Split. $250/cord. 203-232-6340

Pets & Animals

Accessories/Services
Household Pets
Livestock

Household pets

LONG HAIR CHIHUAHUA PUPPIES 1-male, 2 female AKC reg. Vet checked. $700. 860-618-6943

BOYMALTESE 2 PUPPIES ready, 12 Weeks old. AKC reg. Vet checked. $1000. 860-668-8542.

Real Estate For Rent

Apartments
Condos
Garages
Homes
Mobile Homes
Motels & Hotels
Out-of-Town
Rental Services
Roommates
Rooms
Storage
Suburban
Vacation
Wanted to rent

Apartments for rent

NAUGATUCK 1 BR, elect. heat, W/D hookup, no pets. Section 8 OK. $750/mo. 203-982-8447

NAUGATUCK 1st/2nd fl. 2BR, W/D hook-up, no pets/kids, no dogs $750/$850. 203-758-8823/203-966-8117

NAUGATUCK 2 BR off-street parking. Stove & refrig. No pets. $800. 203-723-1402, 203-806-7030

NAUGATUCK 2BR 4yrs. 2nd flr, access near stores/highways, cats overlook. 203-729-6346

NAUGATUCK $800/mth, quiet, spacious 2BR, w/fully dried on 2nd flr w/indoor patio, hdtbs, w/D, & lots of closet space! Pet friendly, good credit a must. Call 203 232-3523.

NAUGATUCK Bright 2nd flr. 2 BR apt, W/D hookup, patio, patio, off-st. prkg. $1000/mth. 203-858-8423.

NAUGATUCK SAFE & QUIET

1 BEDROOM $800; 2 BR $900 includes heat, cooking gas & storage 203-723-5981; 1-914-806-8802

PLYMOUTH Historic 1BR, appls. HW floors, non-smoke. Sec/ref. $825. Open House Sat. & Sun 10-5. 203-585-1810 or 860-283-6980

WATERBURY 0-2 BD UNITS 1ST MONTH RENT FREE $825-$950 ALL UTILITIES INCLUDED In Habib Section Crestina 203-586-2025

WATERBURY 1, 2, 3 & 4 BR units available. Property Management Center (203) 753-6948.

WATERBURY 1, 2, 3, 4 BR Apts & Houses, available NEWLY RENOVATED again! 203-565-5639

WATERBURY 1,2&3 rm units clean, quiet, all secure bldg entry $465/up. Sec 8 OK. 203-753-3259

WATERBURY 1 & 2 & 3 rms, nice, heat & appl, secure buildings, prkg. $450 & up (203) 206-4081

WATERBURY 1 BR East Main line newer Parking, heated incls. Water free cable & internet. No Smoke. $750 w/dep. Ask about FREE Rent! 203-608-4789

WATERBURY 1 BR/1BTH appl & cpts, bus/air no pets Sec8 ready 203-879-2216, 8-10am or 4-6pm

WATERBURY 3 James Pl 4rm 2BR 2nd fl off st prkg, near St. Joseph's Church. Non 203-592-0334

WATERBURY 1720 Baldwin St. 2BR on busline, no pets. 1st mo. and sec. $975. 203-597-9443

WATERBURY 194 Willow St. studio, 1br, 2br start @ $650 w/HW incl. Sec 8 ok. 917-517-6975

WATERBURY 1br, no pet/smoking everything incluc. $525/mo 845-264-5085

WATERBURY 1st flr. 1br, newly built apartment. $750+$750 + sec. 203 586-3552.

WATERBURY 2 & 3 BR Sect 8 ok clean & ready to move in!

Apartments for rent

WATERBURY $850 West end 1BR, 1st fl, all util. incl. No Pets. Pelmale Realty 2038574777.

WATERBURY/CHESHIRE Efficiency 1st flr 2BR w/d/prkg appts, short to middle porch $875 203-828-7777

WATERBURY DOWNTOWN Beautiful renov. apts. in modern 10 story Reservoir Elev. Bldg w/great views: 1 BR $810; Low rentals incl: 1 Parking Space, Carpet/Wall To., Security / Luxury Gym, No Pets. Noble Square Apts. Mgmt. 203-756-1098; 203-837-7428

WATERBURY

EAST END APTS some newly renovated, on busline, convenient to shopping, laundry on premises. 1525-1675. Credit check. 338-7716-6432

WATERBURY Efficiency studio apts $695 /month, prkg no pets/smoking 718-618-6214 10-6:30 weekdays only

WATERBURY

ALTON PARK AREA 2BR 1st flr., 1 bath, HW firs, W/D hkup, off-st. prkg, $1,200 all utils. incl. ALTON PARK AREA 1 full bath, DR, HW firs, off-st. prkg, $1,250/mo. Sec. & ref. req'd. Sect. 8 Ok. 888-437-1845

WATERBURY Lower fl. 2BR 1st flr apt. W/D hkup, off-st prkg, good area $795. John 914-450-3555.

WATERBURY Must see 1st flr. 2BR apt, quiet street, W/D H/U, LR, private porch, $780. 860-997-5465

WATERBURY

PEARL ST. firms. 2BR 2nd flr $750 WALNUT ST 3BR 2nd floor $900 WALNUT ST 1BR 2nd floor $700 WEST MAIN 3 floors 5 BR $1,050 ROCKLEDGE 4 BR Cape $1,350 THEODOR RD. 3BR $975-3682

WATERBURY

RIDGEGATE APTS

2 Story 1/2s 2-3 BR H/HW incl. water, trsh, w/d Need FICO 675. Start $869 Sept. & Oct 3 BR 1/2 off 1st month (qualified tenants only) 203-525-4888 Ext. 106

WATERBURY Robbins St. 1 bedroom $695. Heat & Hot Water included. Call Rosie 203-560-9760

WATERBURY

Studio & 1BR $675-$875/month All Utilities Included-Cable Ready Some 203-465-8188

WATERBURY Town Plot 6rms, appls, W/D hkup, DW St. prkg, no pets/kids, $775/mo. 203 759 1351

WATERBURY 7 WOLCOTT LINE Mod. kits. Some completely updated/maintained MILLTOP MANOR Studios $650; 1 BR from $695; LIBERTY COURT Mod. HW, plant, incl.: studios $840 1 BR $760; both incl. prkg., carpet/vinyl firs, sec. & laundry. No pets. Schools 755-1555. (203) 879-4829

Condos for rent

WATERBURY 2br townhse: 1.5 ba, fpl, granite, $975. No pets 959-867-1255

WATERBURY 1 & 2 BR condos fully appl, W/D, cac $750/mo+sec. 267-879-4126; 203-577-7515

WATERBURY 2BR, 1ba, Bunker Hill Area dead end st., $775 1st & last sec. No pets Frank 203-345-9812

WATERBURY 3 Markham Rd. 2 BR, 1½ bath, quiet neighborhood $875 +sec. Incl. H/W. 203-843-5886

WATERBURY East End very nice 2br, 1.5 ba Townhouse Quiet st. Deck, DW, W/D Hkup $850/mo. No pets. 203-217-2388

WATERBURY Town Plot spacious 2BR 1.5ba c/air deck walk-in closets, carpet $1100. 203-217-2129

WATERTOWN 2BR TH 1.5 ba appl W/D hkup $900, sec. & last mo No pets/smk bets. 203-232-1458

WOLCOTT/WATERBURY line 2 BR, townhse, 1 car garage, heat/HW included $1800. 203-592-2561.

Garages for rent

WOLCOTT Car space avail. 1 garage door, 1400 SF, plenty of parking. $650, call 203-509-8187

Houses for rent

MIDDLEBURY appx 4dr. 2 ba. LR. FR. office, sunporch, staircase, deck, yard. $2800. 203-509-7324

TORRINGTON 4L End 2br Cape w/d hkup on 1st flr. Good end st years, tenant pays all utils. $1000 + 2 month sec. 860-605-9662

WATERBURY single family 5 Bed, Overlook, Bunker Hill, South End Starting @ $1,300 203-510-6177

WATERBURY Town Plot off Bradley 6rm cape and $1,600+sec 203 516-1026, 203 509-8281

WATERBURY West End 4 BR, appl. incl., c/air, gar., no pets. $1,500 + 2 mo. sec. Tony 203 232-4883

WOLCOTT completely remod. 3BR, 1BA, gar., new appls., 1st, last & sec. $1,800. 203-879-3704

WOLCOTT Lakefront, 2BR, 2 car gar., WD hkup, + Lake, no pets. $1,800 + sec. 203-675-8220 Alan

Real Estate For Sale

Mobile home

MANSFIELD 5 units to choose from Starting at $39,900, call owner 203-753-9577

PROSPECT Like new 2013 3 BR, 2 bath single wide $39,500. Liberty 888-747-4482 203 886-7541

Commercial

Business for sale
Commercial for sale, lease, rent

Commercial for sale, lease, rent

WATERBURY 4200 Sq. ft church, fellowship, gym or dance studio, call owner 203-753-9582

WATERBURY FOR RENT Professional Office Space 1,200 SQ.FT. 166 Hamilton Ave 800 SQ. FT. East End Hamilton Avenue 203-336-9851

WATERBURY potential Barber/Beauty Shop or variety store. Please call 203-479-2218

WOLCOTT 1725 sq.ft. bldg. for sale for, inc. Interstate 84 Cente & Wolcott Rd. 203-879-1204

WOLCOTT Business for sale. Busy local diner is looking for a new owner. Well established for 17 years. Loyal customers and great location. Turnkey operation. Call J. Surmas Realty LLC for details. 203-431-1687.

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

CAT Spayed with shots, 4 years old, no dogs/kids. 203 232-8157 leave message

FREE to good home, Labrador Retriever eyes. Good with kids. Moving. 203-982-6479

RAISER free to good home. 203-264-5268

Legals/ Public Notices

Public Notice

In accordance with requirements for the U.S. Department of Transportation as set forth in 49 C.F.R. Part 26, as amended, Greater Bridgeport Transit Authority (GBT) hereby notifies the public that it is recommending the following Disadvantaged Business Enterprise (DBE) goal for applicable procurement contracts beginning October 1, 2015 and ending September 30, 2018. The overall total DBE goal for this period is 3.5%. Information pertaining to this goal and a description of how it was selected is available for inspection from 8:30 a.m. to 4:30 p.m. (Eastern Time) at the GBT's office located One Cross Street, Bridgeport, CT 06610 for 30 calendar days following the date of publication of this notice. The comments received will be sent to the attention of the DBE Officer at the same address, and/or to the Regional Civil Rights Officer, Federal Transit Administration, Region 1, Kendall Square, 55 Broadway, Suite 920, Cambridge, MA 02142-1093

RA 7/20, 2015

LEGAL NOTICE

Notice is hereby given that there will be a caucus of all Republican electors of the town of Middlebury on Tuesday, July 28, 2015 at 7:30 PM at the Bunham Library to select candidates for municipal office.

Ned Bandler & David Hawley Co-Chairmen

R-A July 20, 2015

Legals/ Public Notices

INVITATION TO BID

SEALED BIDS ON THE FOLLOWING WILL BE RECEIVED BY THE DIRECTOR OF PURCHASES IN HIS OFFICE IN THE CITY HALL BUILDING, 235 GRAND STREET, WATERBURY, CT. UNTIL THE DATE AND TIME SPECIFIED WHEN THEY WILL BE PUBLICLY OPENED AND READ. NO BID SHALL BE ACCEPTED FROM OR CONTRACT AWARDED TO ANY PERSON WHO IS IN ARREARS TO THE CITY UPON DEBT OR CONTRACT OR WHO IS A DEFAULTER AS SURETY OR OTHERWISE UPON ANY OBLIGATION TO THE CITY.

Public Works
Opening Date:
August 4, 2015 at 10:30 A.M.
HVAC Improvements - Western Hills Kitchen - A mandatory pre-bid will be held at Western Hills Clubhouse 680 Park Rd, Wtby, CT at 11:30 A.M. on July 24, 2015.
Police Dept.
Opening Date:
August 4, 2015 at 11:00 A.M.
Ammunitions & Related Supplies
Fire Dept.
Opening Date: August 5, 2015 at 10:30 A.M.
Fire Vehicles
Education
Opening Date: August 4, 2015 at 11:30 A.M.
Computer IT Strand Equipment
Opening Date: August 11, 2015 at 10:30 A.M.
RFP – Program Management Svcs. for School Bldg. Construction Projects
Specifications may be obtained by potential bidders by going online www.waterbury-ct.org/purchasing and follow the instructions under the Waterbury eBid link. Please register your business on our new eBid site.
THE CITY OF WATERBURY
ROCCO P. DIGIO
DIRECTOR OF PURCHASES
235 GRAND STREET
WATERBURY, CT 06702
RA 7/20/2015

Legal Notice

Notice is hereby given that the annual caucus of all Republican electors of the town of Morris will be held on Monday (07/27/15 at 7:30PM at the Morris Town Hall Community Hall to endorse candidates for municipal office.

R-A July 20, 2015

Legal Notice
Town of Litchfield
Planning and Zoning Commission

Notice is hereby given that the Planning and Zoning Commission of Litchfield, Connecticut will hold public hearings on August 3, 2015 at 7:00 P.M. at the Town Hall Annex, 80 Doyle Road Bantam, CT, to consider amendments to the Litchfield Subdivision Regulations.

At this hearing interested persons may appear and be heard and written communication will be received. Copies of the amendment, maps and files in the Land Use Office of the Town of Litchfield at the Town Hall Annex, 80 Doyle Road, Bantam, Connecticut.

Thomas Waterhouse
Chairman

R-A July 20 & 30, 2015

WINCHESTER INLAND WETLANDS & WATERCOURSES COMMISSION
LEGAL NOTICE OF DECISIONS

Notice is hereby given that at their Regular Meeting July 15th, 2015 the Inland Wetlands & Watercourses Commission took the following actions:

Application #: IWC 15-11
Applicant: Mack IV, LLC
Location:
814 East Waterbury Blvd
Mass. 808, 809,
886 Lots 1808, 1809 Zone: HLD
Proposed: Removal of stumps, boulders & ledge in within 100' upland review area from lake. Grading new boulder wall and retaining and any existing seeding disturbed area.
APPROVED WITH CONDITIONS

Dated in Winchester this 18th day of July 2015.
Ric Nalette - Chairman
R-A July 20, 2015

Legals/ Public Notices

LEGAL NOTICE
Request For Proposals

The Town of Colebrook is requesting proposals from qualified professional service firms to provide engineering/architectural services for the following project:

Future Use of Colebrook Consolidated School Building Feasibility Study

The Future Use of Colebrook Consolidated School Building Feasibility Study will encompass the analysis of the municipal needs of the town; options /alternatives for the future use of the building including, but not limited, to a municipal use, a leased facility, a sale to a commercial entity and/or demolition and reuse of property, and the initial and on-going cost estimates for the feasibility of each option. The Colebrook Consolidated School building is a 19,000 sq. ft. structure currently being used as a K-6 elementary school.

Scope of Services

The firm will provide engineering/architectural services necessary for the development of the feasibility study including the following:

- An analysis of the municipal needs of the town based on relevant documents and input/recommendations from town boards and commissions and other relevant stakeholders.
- A review of the town's Plan of Development and Conservation of the future use of the school building on that plan.
- An analysis including sustainable, estimated cost and feasibility factors, of optional uses of the building including, but not limited, to a municipal use, a leased facility, a sale to a commercial entity and/or demolition and reuse of property.
- Professional cost estimates for each option and cost analysis for options under consideration.
- Documentation of all findings and presentations to the community.

The firm will provide a detailed cost description for the completion of the Scope of Services. This description will include all applicable billing rates, direct charge schedules and field equipment schedules.

The firm will provide all terms and conditions for any agreement.

A responders' conference, including a tour of the facility, will be scheduled for July 21st, 2015 at 4:30PM.

All questions from prospective applicants should be forwarded to Mr. Chris Johnstone, P.O. Box 5, 562 Colebrook Road, Colebrook, CT 06021 or via email in care of First Selectman Thomas McKeon at tommckeon@colebrookselectman.org or by phone 860-379-3295.

All proposals are to be mailed or hand delivered to Town of Colebrook, P.O. Box 5, 562 Colebrook Road, Colebrook, CT 06021 and must be received by 4:00PM August 6th, 2015 in the Selectmen's Office, Town Hall, 562 Colebrook Road, Colebrook, CT 06021.

The Town of Colebrook reserves the right to accept any or all bids, waive any informalities in the bidding, and make an award in any manner that is the most beneficial to the Town of Colebrook.

Thomas McKeon
First Selectman
RA 7/20/2014

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NOTICE

Bids will be accepted for CVH Sheet Hall Elevator Project until 3 August 3, 2015. Contact J A Rose Construction LLC at 203-879-3405 for access to online specifications and drawings. DBE, MBE, WBE and Section 3 businesses welcome.
AA/EEOE

R-A July 20, 2015

Read current events online with the
RepublicanAmerican
E-edition
A complete electronic version of our traditional published newspaper, right at your fingertips!
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LEGAL NOTICE

Pursuant to Section 19a-486 of the Connecticut General Statutes (C.G.S."), a nonprofit hospital seeking to transfer a material amount of its assets or operation or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty (30) days after the receipt of the letter.

APPLICANTS
Greater Waterbury Health Network, Inc.
Prospect Medical Holdings, Inc.

TOWN
Waterbury, Connecticut

PROPOSAL
Proposed Transfer of Assets of Greater Waterbury Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

DATE AND TIME
Wednesday, August 5, 2015 at 5:00 p.m.

PLACE:
Courtyard by Marriott
63 Grand Street
Waterbury, Connecticut

PROPOSAL DESCRIPTION

Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH") have submitted a proposal to the State of Connecticut's Office of the Attorney General and Office of Health Care Access, a division of the Department of Public Health for the approval of the transfer of certain of the assets of GWHN and its affiliates to one or more affiliates of PMH.

GWHN, a Connecticut non-stock, 501(c)(3) corporation holds interests in numerous entities, joint ventures and affiliates. GWHN is the parent company of The Waterbury Hospital (the "Hospital"). The Hospital, which was built in 1902, is GWHN's primary asset, and is an acute care facility with 357 licensed beds plus 36 bassinets, located in the heart of Waterbury, Connecticut. The towns served by the Hospital include Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury ("Service Area").

PMH is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates hospitals, including, but not limited to, Roger Williams Medical Center and Our Lady of Fatima Hospital in Rhode Island. PMH is the parent entity to thirteen (13) acute care and behavioral hospitals located in Rhode Island, Texas and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 300,000 patients in southern California, South Central Texas and Rhode Island through a network of over 9,000 physicians. Through PMH's Coordinated-Regional-Care model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives. Through collaboration, PMH strives to provide every patient with the quality, affordable healthcare they need and deserve.

The estimated total project cost is $100,000,000, which is subject to certain adjustments based on the terms of the transaction documents. The proposed transaction will include the following GWHN entities or their assets:

- The Waterbury Hospital, a licensed general Hospital;
- VNA Health at Home, Inc., a licensed home health care agency;
- Greater Waterbury Management Resources, Inc., management company;
- Greater Waterbury Health Services, Inc.;
- Alliance Medical Group, Inc., a medical foundation;
- Cardiology Associates of Greater Waterbury, LLC, cardiology medical practice;
- Greater Waterbury Imaging Center, LP;
- Access Rehab Centers, LLC;
- Imaging Partners, LLC;
- Waterbury Gastroenterological Co-Management, LLC;
- Harold Leever Regional Cancer Center, Inc.;
- Heart Center of Greater Waterbury, Inc.; and
- Valley Imaging, LLC.

The proposed transaction is subject to a number of approvals including the consent of GWHN joint venture partners in the case of joint ventures. To the extent required, the Applicants will submit separate CON applications relating to the transfers of certain of the assets.

No services changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the Service Area. This proposed transaction will benefit the current employees and communities served by GWHN.

ADDITIONAL INFORMATION

The determination letter is on file with the Office of the Connecticut Attorney General and the Office of Health Care Access.

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Carpet
Cleaning
Hauling
Plumbing
Roofing

BOB SCAVONE Free Service. 65

CONVERSION APPLICATION

Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("Prospect" or "PMH") (GWHN and Prospect are collectively referred to hereinafter as the "Applicants") hereby respectfully submit to the Attorney General and Commissioner of the Department of Public Health the within application for approval of the proposed acquisition of substantially all of the assets of GWHN and its wholly-owned subsidiaries by one or more subsidiaries of Prospect. The proposed asset purchase is referred to hereinafter as the "Asset Purchase" or the "Transaction".

1. **Identify the contact information for GWHN and PMH, including the individual(s) to whom the Attorney General and the Department of Public Health shall submit bills for contracts with experts or consultants.**

   Response:

   GWHN
   Darlene Stromstad, FACHE
   President/CEO
   Greater Waterbury Health Network, Inc.
   64 Robbins Street
   Waterbury, CT 06708
   Telephone: 203.573.7101
   Facsimile: 203.573.6161
   Email: dstromstad@wtbyhosp.org

   PMH
   Jonathan Spees
   Senior Vice President
   Prospect Medical Holdings, Inc.
   10780 Santa Monica Blvd.
   Suite 400
   Los Angeles, CA 90025
   Telephone: 310.943.4500
   Facsimile: 310.943.4501
   Email: Jonathan.Spees@prospectmedical.com

   Please submit bills for contracts with experts or consultants to Mr. Spees at the address listed above.

2. Provide an executive summary of the application for approval.

Response:

GWHN is a Connecticut non-stock, 501(c)(3) corporation which holds interests in numerous entities, joint ventures and affiliates. GWHN is the parent company of The Waterbury Hospital (the "Hospital"). The Hospital, which was built in 1902, is GWHN's primary asset, and is an acute care facility with 357 licensed beds plus 36 bassinets, located in the heart of Waterbury, Connecticut. GWHN, through the Hospital and other affiliates, provides acute care hospital services, physician services, diagnostic imaging, as well as rehabilitation and home health care services.

GWHN, like many community health networks, has experienced financial difficulties and has been seeking an affiliation with a larger, well-capitalized healthcare system for several years. It has previously submitted two conversion applications. Prospect is the third proposed affiliation.

Prospect is a for-profit, privately-owned Delaware corporation that owns and operates thirteen acute care and behavioral hospitals, and a network of 32 specialty and primary care clinics, in Southern California, Texas and Rhode Island.

The Applicants have proposed that one or more subsidiaries of Prospect acquire substantially all of GWHN's assets for a total purchase price of approximately $53 million (including net working capital of approximately $21 million (as of August 31, 2015) and assumption of $6.5 million of GWHN capital leases) and a future capital commitment of $51.5 million. It is anticipated that the net assets of GWHN comprised of unrestricted cash and investments will be used to satisfy certain obligations of GWHN which are not assumed by Prospect at the closing. Certain other obligations of GWHN may be paid after the closing and the Applicants have made provisions for the satisfaction of those obligations. Subject to the approval of the Attorney General and the Superior Court, charitable assets that may not be used for such obligations will fund an independent foundation or, at the direction of the Superior Court, be directed to appropriate uses. (See discussion of the "Independent Foundation" in response to Question 10, below).

The proposed sale of GWHN's assets represents an innovative solution to long-standing challenges and offers GWHN's service area patients continued access to GWHN's services and facilities. Many of these services and facilities will be enhanced through capital investments and operating efficiencies. The proposal is financially feasible, ensures and enhances access, and improves the financial health of Connecticut's health care system.

3. Describe the terms of the proposed Asset Purchase. This section should include, but is not limited to:

a. descriptions of GWHN, PMH, the assets to be transferred pursuant to the Asset Purchase, any assets excluded from transaction, the assumed and excluded liabilities of the Asset Purchase, any commitment to spend funds on capital items, and any plan to expand or acquire new programs or services;

b. a financial analysis of the proposed transaction that identifies the source of funding for PMH's initial purchase price, the uses of the proceeds of the transaction, and the valuations of included and excluded assets; and

c. a balance sheet of the proposed transaction that lists the assets and liabilities of the nonprofit hospital as of the most recent quarter end, and then sets forth the projected balance sheets of the surviving nonprofit entity, if any, and of the for-profit purchaser that reflect the agreement of the parties regarding the assets and liabilities retained and assumed by the respective parties post-close.

Response:

Description of GWHN

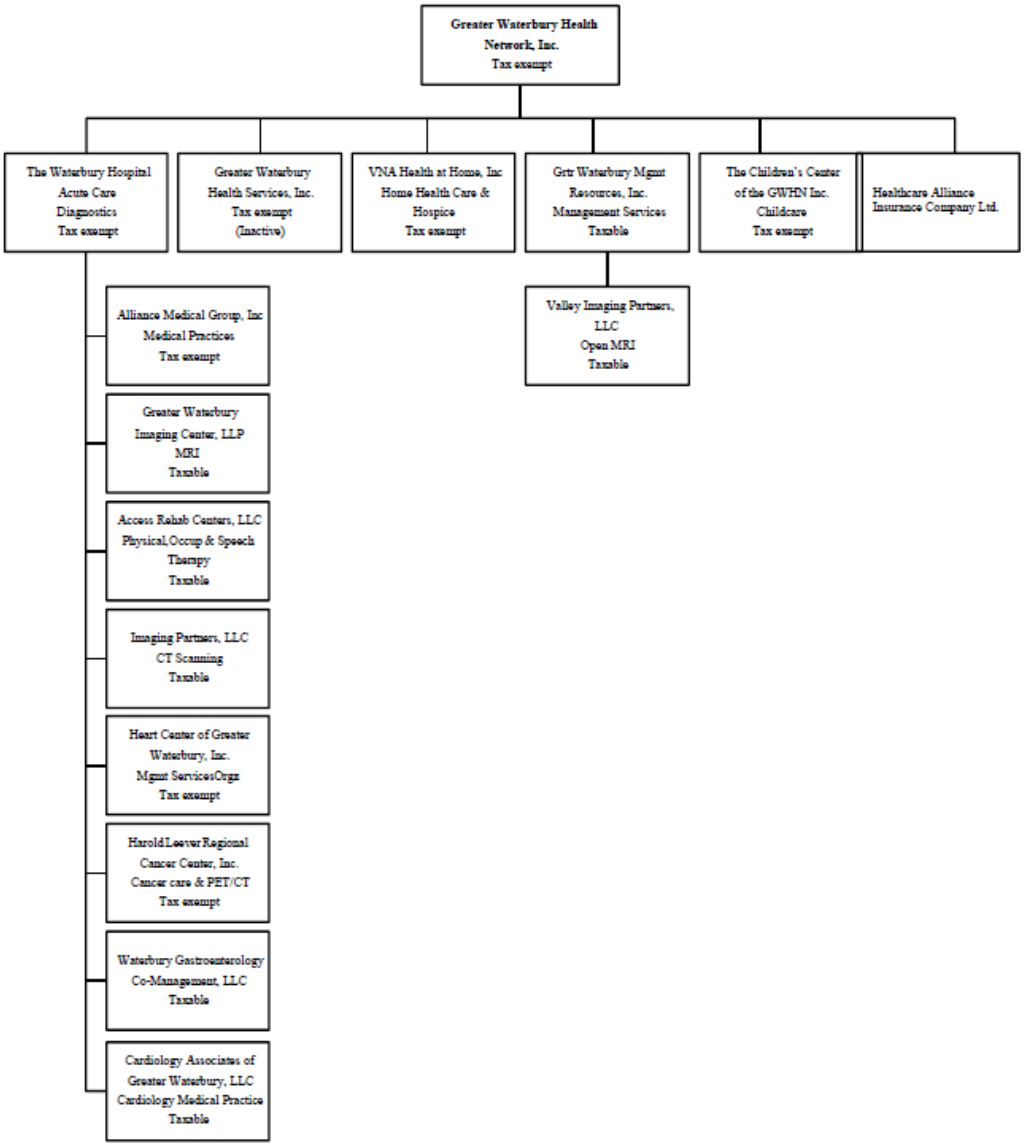
GWHN is a Connecticut non-stock, 501(c)(3) corporation which holds interests in numerous entities, joint ventures and affiliates. GWHN is the parent company of The Waterbury Hospital (the "Hospital"). The Hospital, which was built in 1902, is GWHN's primary asset, and is an acute care facility with 357 licensed beds plus 36 bassinets, located in the heart of Waterbury, Connecticut.

The Waterbury Hospital is a "safety net" hospital. It treats a large number of Medicare, Medicaid and uninsured patients. Discharges for these three payers represent approximately 80% of the total patient days and 75.6% of emergency room outpatient visits. Combining both inpatient days and emergency department outpatient visits, only 22% of its patients have commercial insurance. The Hospital admitted 10,729 inpatients, 917 newborns, had over 48,500 total emergency department visits (excluding observation visits), and performed an estimated 1,950 inpatient surgeries and 4,288 outpatient surgeries.

Through GWHN's affiliates, physician-specialists and outpatient clinics provide health care in community settings. The affiliates and subsidiaries include: Access Rehab Centers LLC, HAIC Indemnity Company, LLC, Imaging Partners, LLC, Greater Waterbury Imaging Center Limited Partnership, Harold Leever Regional Cancer Center, Inc., Heart Center of Greater Waterbury, Inc., Alliance Medical Group, Inc., Waterbury Gastroenterological Co-Management Company, LLC, Cardiology Associates of Greater Waterbury, LLC, Greater Waterbury Health Services, Inc., VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and Children's Center of Greater Waterbury Health Network, Inc.

The Table of Organization on the next page depicts GWHN and its affiliates.

ORGANIZATION CHART



GHWN is an equity holder of the following entities:

- **Healthcare Alliance Insurance Company, Ltd. (GWHN is a 50% owner)**. Healthcare Alliance Insurance Company, Ltd. ("HAIC") is a Cayman Islands-based captive insurance company owned jointly by Griffin Health Services, Inc., Milford Health and Medical, Inc., and GWHN. HAIC was created to offer professional malpractice and general liability insurance coverage to Griffin Hospital, Milford Hospital, Waterbury Hospital and members of their respective medical staffs. Milford Hospital is no longer an owner of HAIC.

- **Greater Waterbury Health Services, Inc. (wholly-owned by GWHN)**. Greater Waterbury Health Services, Inc., a not-for-profit corporation, was organized to provide for the contracting and management of tax-exempt community health services and programs in which GWHN may engage. Currently, there is no activity in this subsidiary.

- **VNA Health at Home, Inc. (wholly owned by GWHN)**. VNA Health at Home, Inc., ("VNA") is a non-profit, non-stock corporation established in 1939 and affiliated with GWHN since 1996. VNA is a home health care agency that provides skilled nursing care, speech, physical and occupational therapy, medical social work and hospice care throughout the Greater Waterbury region. It is located at 27 Siemon Company Drive, Watertown, Connecticut 06795.

- **Greater Waterbury Management Resources, Inc. (wholly-owned by GWHN)**. Greater Waterbury Management Resources, Inc. ("GWMRI") is a taxable corporation. GWMRI is a medical service organization originally organized to provide services to effectively manage medical group practices. While GWMRI has been in existence since 1984, there has been minimal activity since the formation of AMG. GWMRI is located at 1625 Straits Turnpike, Middlebury, Connecticut.

    - **Valley Imaging, LLC.** Valley Imaging, LLC ("Valley Imaging") is a Connecticut limited liability company formed in 2002 and is owned by GWMRI and Diagnostic Radiology Associates, LLC. GWMRI has a 49% ownership interest in Valley Imaging. Located at 799 New Haven Road in Naugatuck, Valley Imaging offers open MRI Scanning service to outpatients in the service area.

- **Children's Center of Greater Waterbury Health Network, Inc. (wholly-owned by GWHN)**. Children's Center of Greater Waterbury Health Network, Inc., ("CCGWHN") a not-for-profit tax exempt corporation, is a nationally-accredited, state-licensed childcare center. CCGWHN provides a staff of early childhood professionals to care for children from six weeks to five years of age and has been providing childcare services since 1997. It is located at 172 Grand Avenue, Waterbury, Connecticut.

- **The Waterbury Hospital (wholly-owned by GWHN)**. The Waterbury Hospital, in operation since 1890, is a 357-licensed bed (excluding bassinets) acute-care teaching

hospital which provides a full range of inpatient, outpatient and ancillary services in the city of Waterbury near the junctions of Route 8 and Interstate 84. The Hospital operates as an acute care teaching hospital, and has interests in the following entities:

- **Alliance Medical Group, Inc. (**Wholly-Owned By The Hospital)
  Alliance Medical Group, Inc. ("AMG") is a tax exempt 501(c)(3) medical foundation and a wholly owned subsidiary of the Hospital. AMG is the largest hospital-affiliated, multi-specialty group in the Waterbury area with more than 100 physicians and health care providers practicing in the following specialties: Emergency and Internal Medicine, Pediatric and Adolescent Medicine, Breast Surgery, General Surgery, Endocrinology, Pulmonary, Rheumatology, Infectious Disease/Travel Medicine and Sleep Medicine. AMG has locations at:

  - 1625 Straits Turnpike, Suite 302, Middlebury, Connecticut
  - 40 Main Street, North, Woodbury, Connecticut
  - 305 Church Street, Naugatuck, Connecticut
  - 130 South Main Street, Thomaston, Connecticut
  - 140 Grandview Avenue, Suite LO-1 and LO-6, Waterbury, Connecticut
  - 1211 West Main Street, First Floor, Waterbury, Connecticut
  - 51 Depot Street, Suite 506, Watertown, Connecticut

- **Greater Waterbury Imaging Center Limited Partnership.** (64% owned by the Hospital). The Hospital is the general partner of Greater Waterbury Imaging Center Limited Partnership, a Connecticut limited partnership formed to develop and operate a medical diagnostic imaging center. It is located at 68 Robbins Street, Waterbury, Connecticut.

- **Access Rehab Centers LLC.** (65% owned by the Hospital) Access Rehab Centers LLC). Access Rehab Centers LLC is a limited liability company formed in 1998 and owned by the Hospital and Easter Seal Rehabilitation of Greater Waterbury, Inc. It offers the region's largest and most comprehensive array of outpatient physical, occupational and speech therapy to adults and children. Access also provides physical therapy services on an inpatient basis to the Hospital. Access has locations at:

  - 134 Grandview Avenue, Waterbury, Connecticut
  - 715 Lakewood Road, Waterbury, Connecticut
  - 2154 East Main Street, Waterbury, Connecticut
  - 22 Tompkins Street, Waterbury, Connecticut
  - Waterbury Hospital, 64 Robbins Street, Waterbury, Connecticut
  - 1625 Straits Turnpike, Middlebury, Connecticut
  - 70-G Bennett Square, Southbury, Connecticut
  - 84 Oxford Road (Route 67), Oxford, Connecticut
  - 305 Church Street, Suite 16, Naugatuck, Connecticut
  - 131 Main Street, Thomaston, Connecticut

- **Imaging Partners, LLC** (85% owner). Imaging Partners, LLC is a limited liability company owned by the Hospital and a private radiology practice, Diagnostic Radiology Associates, LLC. Formed in 2001, Imaging Partners owns a 32 Slice CT scanner. It is located at 134 Grandview Avenue, Waterbury, Connecticut.

- **Waterbury Gastroenterological Co-Management Company, LLC.** Waterbury Gastroenterological Co-Management Company, LLC, is a limited liability company established to provide management services to the Hospital to improve and, where appropriate, maintain the overall quality, efficiency, and effectiveness of the Hospital's gastroenterology service line. The Hospital is sole Class H Member and has certain management rights; the Physician owners, Class P Members, assist the Hospital in providing such management services. It is located at 64 Robbins Street, Waterbury, Connecticut.

- **Cardiology Associates of Greater Waterbury, LLC**. Cardiology Associates of Greater Waterbury, LLC is a cardiology practice established in 2010 and is wholly owned by the Hospital. The practice is comprised of eight employed board certified cardiologists, three of whom are interventional cardiologists. The practice has approximately 20,000 active patients. It is located at 455 Chase Parkway, Waterbury, Connecticut.

In addition to the above subsidiaries, the Hospital is a corporate member of two not-for-profit joint ventures with Saint Mary's Hospital ("SMH" or "Saint Mary's") that provide specialty services:

- **Harold Leever Regional Cancer Center, Inc**. Harold Leever Regional Cancer Center, Inc. ("HLRCC") is a 501(c)(3) corporation. The Hospital and Saint Mary's are equal corporate members of HLRCC. Formed in October 2002, HLRCC combined both hospitals' existing medical and radiation oncology businesses into one combined program to better meet the needs of the community. HLRCC provides state of the art cancer diagnostic and radiation services with two (2) linear accelerators and a PET/CT Scanner. The community's two private medical oncology practices provide services at HLRCC. HLRCC is located at 1075 Chase Parkway, Waterbury, Connecticut.

- **Heart Center of Greater Waterbury, Inc**. Heart Center of Greater Waterbury, Inc. ("HCGW") is a 501(c)(3) corporation. The Hospital and Saint Mary's are equal corporate members of HCGW. HCGW was used to develop a joint cardiac program. It does not have assets or significant operations of its own. Under this joint program, the two hospitals provide area residents with advanced cardiac services, including cardiac angioplasties and open heart surgery on both hospitals' campuses. The program performs over 600 angioplasties and 200 open heart surgeries annually. It is has two locations: one at the Hospital at 64 Robbins Street, Waterbury, Connecticut and the other at Saint Mary's Hospital, 56 Franklin Street, Waterbury, Connecticut.

Description of Prospect

Prospect is a Delaware corporation with its principal place of business located in Los Angeles, California. Prospect owns and operates thirteen acute care and behavioral hospitals in Rhode Island, Texas and California. Prospect also owns a network of specialty and primary care clinics in each of its regions. Through its network of approximately 8,900 physicians, Prospect's medical group segment manages the provision of physician services to approximately 260,000 patients in Southern California, South Central Texas and Rhode Island.

Prospect currently owns the following hospitals:

- Los Angeles Community Hospital;
- Los Angeles Community Hospital at Bellflower;
- Los Angeles Community Hospital at Norwalk;
- Southern California Hospital at Hollywood;
- Southern California Hospital at Van Nuys;
- Southern California Hospital at Culver City;
- Foothill Regional Medical Center;
- Nix Health (four campuses);
- Roger Williams Medical Center (RI); and
- Our Lady of Fatima Hospital (RI)

Prospect aligns its hospitals and physicians under a model referred to as Coordinated Regional Care ("CRC"). CRC provides for clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs. This model has been highly successful in aligning physicians with Prospect hospitals and improving quality, efficiency and financial performance in California. Local versions of the model have been implemented in Texas and Rhode Island with similar success. Through Prospect's CRC model, Prospect works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives. Through collaboration, Prospect strives to provide every patient with the quality, affordable healthcare they need and deserve.

Form of the Transaction

The APA commits GWHN and its wholly-owned subsidiaries, subject to satisfaction of various conditions, to the sale of substantially all of their assets to one or more subsidiaries of Prospect. The draft APA is based on the Letter of Intent signed by GWHN and Prospect on May 1, 2015, as amended (as amended, the "Letter of Intent"). After the execution of the Letter of Intent, GWHN's liquidity and financial performance deteriorated (due, in part, to recently implemented state budget cuts) and size of the pension liabilities

was found to be greater than anticipated. The structure of the Transaction was amended to accommodate the need for additional cash. The draft APA is subject to any changes that may be required as the result of Prospect's continuing due diligence review or to reflect changes in the Transaction which might be required to assure that there are sufficient funds available as of the closing to consummate the proposed Transaction (see further discussion at Questions #2 and #10). Copies of the Letter of Intent and draft APA are set forth in **Exhibit Q3-1** and **Exhibit Q3-2**, respectively. In addition, set forth in **Exhibit Q3-3** is a balance sheet of the Asset Purchase which lists the assets and liabilities of the Hospital as of August 31, 2015 and the projected balance sheets of the surviving nonprofit entity and the for-profit purchaser that reflect the agreement of the parties.

GWHN Assets to be Transferred

- All rights, title, and interest in and to the facilities, including, without limitation, the Hospital, its business operations, and other related health care assets.
- Equipment.
- Net Working Capital, defined as accounts receivable, inventory and supplies, any prepaid expenses and deposits that have continuing value to Prospect's subsidiary(ies) that purchase the assets of GWHN, less accounts payable and accrued expenses.
- Patient, medical, personnel and other records of the facilities.
- Licenses, permits and trade names.
- Certain assumable contracts of the facilities.
- Interests in subsidiaries and affiliates, other than wholly-owned subsidiaries where assets, instead of interests, are being transferred, and Greater Waterbury Health Services, Inc., CCGWHN and HAIC, which are not being transferred.
- Interests in all property arising or acquired in the ordinary course of the operation of the business between the date of execution of the letter of intent and the closing.
- All other property, whether tangible or intangible, of every kind, character, or description owned by GWHN and used or held for use in the operation of the Facilities.

GWHN Assets Excluded from the Transaction

- Cash and cash equivalents.
- Board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, working capital trust assets, and assets and investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing.
- Prepaid expenses not assumed by Prospect.
- All insurance proceeds arising in connection with the operation of the assets or the facilities for periods prior to closing to the extent that all damage to the Assets has been repaired.
- All amounts due or to become due to GWHN from the Medicare, Medicaid or other payor programs in respect of cost report periods ended on or prior to closing.
- Interests and assets of in Greater Waterbury Health Services, Inc., CCGWHN and HAIC.

Liabilities Assumed by Prospect

- certain trade accounts payable and current liabilities as of the closing.
- assumed contracts and leased personal property.
- certain paid time off benefits of employees.
- certain capital lease obligations.
- certain liabilities for professional malpractice claims which were incurred but not reported ("IBNR") prior to the closing.
- tax liabilities commencing on or after the closing.
- the asbestos abatement liability.
- certain employee benefit plans.

Liabilities Retained by GWHN

- Debt (to be paid off as of the closing).
- Claims or potential claims for workers' compensation, medical malpractice or general liability relating to events asserted to have occurred and been reported prior to closing.
- Liabilities or obligations associated with or arising out of any of the GWHN excluded assets.
- Liabilities or obligations with respect to cost report periods prior to closing arising under Medicare, Medicaid or other payors.

Purchase Price and Use of Proceeds

Subject to the terms and conditions of the APA, the Purchase Price is $31.8 Million plus the assumption of $6.5 million of capital leases of GWHN plus or minus the amount by which the net book value of the net working capital is greater or lesser than $6.8 Million. Prospect will assume certain liabilities (which will reduce the cash Purchase Price) and GWHN will retain certain liabilities.

Post Closing Governance

The post-closing hospital will be governed by a board of directors controlled by Prospect (the "Hospital Board"). The Hospital Board will have oversight and ultimate authority over the affairs of the hospital and the purchased assets.

The Hospital Board will be advised by a community advisory board ("Local Board") comprised of between nine (9) and twelve (12) people. The Local Board will:

- Make recommendations and suggestions regarding the mission, vision and value statements with respect to GWHN post transaction.
- Make recommendations and suggestions with respect to medical staff credentialing, disciplinary action of staff physicians, and compliance with accreditation requirements.

- Provide input on policies and clinical programs.
- Provide input in the development and review of strategic plans.
- Provide input on operating and capital budgets.
- Provide input and support physician recruitment efforts.
- Provide input on succession plans for executive leadership at the hospital.
- Promote community health initiatives, fostering community relationships and identifying service and education opportunities.
- Monitor the commitment to maintain and improve quality indicators.

Capital Commitment

Prospect agrees to spend or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) not less than the Capital Amount in the seven (7) years following the Closing Date on capital projects, including routine and non-routine capital expenditures, at, or for the benefit of, the Hospital Businesses and/or the acquisition, development and improvement of hospital, ambulatory or other health care services in the greater Waterbury, Connecticut community. Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed after Closing that (i) discriminates against, or adversely affects a disproportionate number of, for-stock hospitals or other for-profit health care entities or (ii) causes Buyer to suffer a material decline in EBIDTA on a consolidated basis, then, in either event, Buyer shall be relieved of its obligation to provide the above capital commitment and shall be required to consult with the Local Board to determine an alternate mutually agreeable capital commitment of Buyer that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement. (See **Exh. Q.3-2,** Section 6.10 of the APA.)

Expansion

At this time, plans to expand or acquire new services have not been determined but will reflect Prospect's Coordinated Regional Care model.

4. Provide copies of all contracts, agreements, memoranda of understanding, and pro forma financial statements relating to the proposed Asset Purchase.

Response:

Please see **Exhibit Q3-1** and **Exhibit Q3-2**, which set forth the Letter of Intent and APA, respectively. In addition, a copy of the Mutual Non-Disclosure Agreement entered into by GWHN and Prospect, dated March 9, 2015, is set forth in **Exhibit Q4-1**. Prospect and GWHN have also entered into an Interim Consulting Services Agreement pursuant to which Prospect will provide certain consulting services to GWHN. A copy of the Interim Consulting Services Agreement is set forth in **Exhibit Q4-2.**

5. Describe the due diligence undertaken by GWHN in deciding to enter into the Asset Purchase. This section should include, but is not limited to, considerations regarding the current financial condition of GWHN and any projected financial condition of GWHN, any professional assessments of or reports regarding GWHN or PMH, any and all alternatives explored by GWHN or other offers received by GWHN, the reasons for rejecting such alternatives and offers, GWHN's selection of PMH, and the specific terms of the Asset Purchase. In addition, the parties should discuss the due diligence in obtaining the fairness evaluation required by Conn. Gen. Stat. § 19a-486a(c)(5), including providing a copy of said independent expert's resume or other documentation of his or her qualifications and describing the process undertaken to identify and retain this person as an independent expert.

Response:

BACKGROUND

This Application is the continuation of the process that GWHN began in 2010. This is the third application that GWHN has submitted with respect to a for-profit affiliation. Previous applications were submitted in 2010 and 2013[1]. In each instance, the co-applicant has terminated the proposed transaction. We have described the process in its entirety in order to reflect the care, diligence and commitment that the GWHN board, management and community has committed to the continuity of high quality healthcare in the greater Waterbury community and the protection of GWHN's charitable assets.

The Waterbury Hospital is a "safety net" hospital. It treats a large number of Medicare, Medicaid and uninsured patients. Discharges for these three payers represent approximately 80% of the total patient days and 75.6% of emergency room outpatient visits. Combining both inpatient days and emergency department outpatient visits, only 22% of its patients have commercial insurance. The greater Waterbury community and the City of Waterbury itself generally lag behind the rest of the state in economic terms. The City of Waterbury compared to the rest of the state has: a significantly higher unemployment rate (8.2% vs. 6.4% in March 2015), lower median household income ($41,499 vs. $69, 243), lower level of educational attainment, larger minority populations, and a lower rate of home ownership (49.6% vs. 68.9%).[2]

Not surprisingly, as a result of declining governmental and commercial reimbursement and the general economic climate in its geographical area, the Hospital has experienced a number of consecutive years of losses. The nationwide unavailability of capital for nonprofit hospitals has hit the smallest community hospitals the hardest.

[1] LHP Transaction: OHCA Docket No. 12-31755-486, Attorney General Docket No.: 12-486-02 and Vanguard transaction: OHCA Docket No. 13-31838-CON; Attorney General Docket No.: 13-486-01.
[2] US Census Data (2012) Waterbury Profile; Economy at a Glance by US Bureau of Labor Statistics.

2005-2008.

Following multiple years of operating losses, GWHN engaged Kaufman Hall in 2005 to evaluate the economics of consolidating the Hospital and Saint Mary's Hospital. Kaufman Hall concluded that even a consolidated institution would struggle financially. Despite this assessment, in 2006, the Hospital and Saint Mary's had discussions regarding a possible affiliation which never materialized.

Discussions between the two hospitals resumed in 2007, and the Office of Health Care Access conducted a special study of the status of health care services in the City of Waterbury (DN 06-30760-VST, attached hereto as **Exhibit Q5-1**). OHCA concluded that both hospitals were in financial distress, had aged facilities and lacked access to capital. The report encouraged either the consolidation of the two hospitals or the planned closure of SMH. Affiliation discussions continued into 2008; however, the Hospital and SMH were not able to reach agreement on terms and no capital partner or state funding was secured to fund the anticipated $130 million merger cost.

2008-2010.

When the United States entered a deep recession in 2008, GWHN was impacted by lower healthcare utilization, stagnant or declining reimbursement rates, and it experienced significant financial difficulty, leading to a default in its bond covenants in 2009. As part of the forbearance arrangement with its bondholders, GWHN and the Hospital entered into an agreement with PricewaterhouseCoopers, LLC ("PwC") in 2009 to identify top challenges and risks for GWHN, define operational improvements, define revenue cycle improvements and set physician initiatives.

Top challenges identified by PwC included: risks associated with IT implementation; skill set of management across the organization; ongoing capital needs and sufficient access to capital for strategic investments; healthcare reform and declining reimbursements; and strained relationships among board, physicians, management and unions.

PwC recommended strategies for improving clinical and financial performance; strategies were implemented with only partial success. In response, the Board realigned the executive team in 2011. In the first six months, this new team reduced expenses by $6 million, instituted service improvements, improved core measures and made modest capital improvements as a result of the savings gained by successfully refinancing its tax exempt debt. However, these improvements were not enough to secure the long-term resources required to sustain the current health system.

In addition, in 2010 Kaufman Hall, a well-known healthcare advisor, was retained to identify near-term capital needs. Kaufman Hall identified over $50 million in capital

improvements required over 5 years to keep the Hospital operational, money GWHN simply did not have and could not secure in the open market.

The Kaufman Hall and PricewaterhouseCoopers reports are attached hereto as **Exhibit Q5-2**.

With difficulty, in late 2010, the Hospital was able to refinance its CHEFA debt in a private offering. However, continued financial difficulty coupled with the consultants' assessment of capital need and dismal prospects for securing such capital caused the Board of Directors to reconsider an independent hospital strategy.

SEARCH FOR A CAPITAL PARTNER

In late 2010, the Executive Committee of the GWHN Board recommended that the Hospital seek a capital partner and acknowledged that this might include a merger; a task force was formed. In early 2011, the Board of Directors engaged respected health care bankers, Cain Brothers, to develop strategic alternatives including partnership, merger or sale consistent with the GWHN Board's stated goals and objectives. The task force met on March 4, 2011.

At the GWHN Board's direction, Cain Brothers contacted 14 parties to assess interest. Seven of the interested parties executed confidentiality agreements and received a Confidential Information Memorandum ("CIM"). Four parties responded with non-binding proposals. Cain Brothers engaged these parties in negotiations to improve the initial indications of interest. During the negotiation phase, one of the four parties did not respond to requests and opted out of the process.

During May, June and July 2011, Cain Brothers worked with GWHN's task force and the three remaining entities to improve their indications of interest. Despite repeated entreaties, the sole tax exempt entity responding to the CIM did not provide responsive documents, leaving two entities for the Board to evaluate. During this time, the task force updated the Board at each monthly board meeting.

During the GWHN Board's review of the three proposals over several meetings, Cain Brothers facilitated a discussion of the benefits and risks of each proposed transaction. After careful consideration, the GWHN Board determined that the benefits of one united health system, accompanied by one new state-of-the-art hospital, presented a once in a lifetime opportunity for greater Waterbury. The GWHN Board voted on August 15, 2011 to authorize the negotiation of definitive agreements with LHP/Saint Mary's. On August 18, 2011 the parties entered into a letter of intent for a joint venture ("LHP Joint Venture"). GWHN and LHP submitted an application for conversion on April 23, 2012.

Despite a year of extraordinary efforts by the parties, community leaders and government officials, significant impediments to the proposed LHP Joint Venture remained. In late August 2012, LHP terminated the proposed joint venture citing the

increasing costs of building the proposed replacement hospital and the inability to satisfy all constituents regarding issues related to the Ethical and Religious Directives for Catholic health care services.

FINDING A SECOND PARTNER (2012 – 2014)

On September 4, 2012, the GWHN Board reconvened and authorized the Task Force to continue discussion with SMH and LHP as well as to pursue other opportunities in the market. With Cain Brothers' assistance, GWHN sought additional proposals for capital partners in late September 2012 and received indications of interest in mid-October 2012.

At the Board's direction, Cain Brothers requested proposals from a select group of organizations interested in a strategic relationship with GWHN. The GWHN Board confirmed the following objectives as a guide for evaluating potential partners:

- Ensure the Hospital remains a viable health care entity, providing the highest safety and quality health care services to the Greater Waterbury community for the long-term;
- Provide sufficient capital to meet deferred, current and future capital needs for the Hospital's physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology;
- Continue a meaningful local governance presence at the Hospital that represents both physicians and the Greater Waterbury community;
- Develop and implement an ambulatory service strategy to best position GWHN for a successful transition in changing health care delivery methods;
- Develop and implement regional tertiary care relationships for the betterment of health care delivery to the community;
- Deploy repeatable and scalable tools and clinical care services to continually improve the health of the community;
- Enhance the Hospital's medical staff by attracting and retaining physicians through access to available capital partner funds to support such growth;
- Maintain high satisfaction scores by patients, physicians, employees and volunteers; and
- Continue charitable care delivery and funding.

Non-disclosure agreements ("NDA") were distributed to eleven entities, including two tax–exempt healthcare systems. Five parties executed NDAs and received a CIM, which is attached as **Exhibit Q5-3**. Of the five entities receiving CIMs, two submitted proposals. Neither tax-exempt system responded to the solicitation process.

Table B: Process Summary

TAX STATUS	LOCATION	RECEIVED CIM	REPLIED TO CIM
Exempt	CT	No	N/A
Exempt	CT	No	N/A
Taxable	National	No	N/A
Taxable	Southeast/Southwest	Yes	No
Taxable	South/Southwest	No	N/A
Taxable	West	Yes	N/A
Taxable	West	Yes	Yes
Taxable	Midwest, South, Northeast	Yes	No
Taxable	New England	No	N/A
Taxable	National	No	N/A
Taxable	National	Yes	Yes

On October 17, 2012, Cain Brothers presented the two proposals that were received to the Task Force; the proposals were from Vanguard and Prospect. Cain Brothers arranged for representatives of the two proposers to meet at length and in person with the Task Force. Cain Brothers presented the proposals focusing on (i) the form and economic value of the proposed transaction; (ii) the proposed governance and continuation of services, and (iii) each entity's business strategy, proposed transaction timing, and ability to close. Cain Brothers noted that Prospect proposed an asset purchase transaction, but was open to a joint venture arrangement, while Vanguard proposed both an asset purchase transaction and a joint venture arrangement.

The Task Force discussed the positives and negatives of each proposal, and all members agreed that they would prefer a joint venture to an asset purchase, believing that the joint venture model will better ensure continuing community engagement with the Hospital. It discussed each entity's experience with running hospitals, experience with the CON process, experience in New England, strategy, familiarity with the Waterbury market, and apparent willingness to deploy capital, among other topics. It concluded that it would recommend Vanguard to the Board.

The following table summarizes key features of the proposals received:

Table C: Key Features of Initial Proposals Received

	(Candidate A[3])	**Vanguard Health Systems**	
Form of Transaction	Asset purchase, though flexible and open to Joint Venture arrangement if preferred by GWHN.	Asset Purchase	Joint Venture with GWHN to retain 20% ownership (ownership percentages
Total Unadjusted Transaction Value	~$115.4 million	~$147.9 million	
Excluded Assets	Children's Center	None	
Cash Proceeds to Foundation	$16.3 million	$11.2 million	$8.8 million
Net Foundation Assets	~$45.4 million	~$72.9 million	
Long Term Capital Commitments	Minimum of $70 million over a 5-year period.	Minimum of $75 million over a 5-year period.	

[3] This candidate was Prospect

Governance	• Anticipated a local board to be created consisting of local community leaders and physicians. • Would rely on current board members, or a subset thereof, to comprise the new board. • Local board to determine timing of capital contributions, with Purchaser approval required.	• Anticipated participation of existing GWHN Board on a hospital advisory board.	• Anticipates creating a local Prospect Waterbury board comprised of members from GWHN and Prospect. • Only requirement was to have enough "control" such that GWHN financials are consolidated with Vanguards.
Continuation of Services	Anticipated maintaining all existing clinical services.	Committed to maintaining all existing core service lines for at least 10	
Expansion of Services	Would continuously evaluate market to identify new opportunities with substantial input from local management team.	Will continuously evaluate market to identify new opportunities with substantial input from local management team.	
Timing	Not explicitly provided.	30-45 days due diligence prior to signing a Definitive Agreement.	
No Sale Provision	Had never sold any of its hospitals and did not anticipate selling GWHN post acquisition.	Does not purchase hospitals to close or sell them and open to discussing time commitment for retaining ownership in GWHN.	
Right of First Refusal / Repurchase Rights	Did not expect any rights of first refusal or repurchase rights, though open to discussing with GWHN.	Would allow GWHN right of first refusal or grant certain repurchase right to GWHN upon occurrence of certain events.	
Charity Care	Would adopt GWHN's charity and indigent care policies.	Will put in place a policy that is "at least as favorable to patients" as the existing GWHN policy.	

Employee Matters	Expected to offer employment to substantially all employees of GWHN, including management.	Expected to offer employment to substantially all employees of GWHN.

A special joint meeting of the boards of GWHN and the Hospital was called for October 25, 2012. At the meeting, the Task Force reported on its work with Cain Brothers: finding the best option for Waterbury and ensuring that the community would remain involved with running GWHN and the Hospital. At the Board Meeting, Cain Brothers presented its work the resulting proposals Cain Brothers contacted eleven entities about entering into a potential transaction with GWHN and the Hospital. Five of those entities signed NDAs, and Cain Brothers received written proposals from two of those five entities. Mr. Horowitz of Cain Brothers explained each entity's history, experience and current projects. He stated that initially Prospect proposed only an asset purchase and was asked to also propose a joint venture; Vanguard proposed either an asset purchase or a joint venture. Mr. Horowitz described the details of both proposals, including financial terms, governance structure, acceptance of liability, and strategic plans among other details. He noted that in reviewing the details of each proposal, the Task Force met in person with representatives of both proposers.

The GWHN Board Chair presented the Task Force's recommendation that the GWHN Board accept Vanguard's proposal because it would more closely meet the needs of GWHN, the Hospital and the Greater Waterbury community. Factors cited in this recommendation included Vanguard's presence in the Northeast, its familiarity with the Waterbury market and its experience with the Certificate of Need process in other States. After lengthy discussions regarding the experience and qualifications of both Vanguard and Prospect, the Boards of GWHN and the Hospital voted unanimously to authorize the negotiation of a letter of intent with Vanguard. GWHN and Vanguard executed a Letter of Intent to form a joint venture on October 29, 2012.

Thereafter, the due diligence period commenced the results of the parties' diligence and several intervening transaction necessitated changes to the deal reflected in the original Letter of Intent as well as additional diligence on the part of GWHN's board. After the execution of the Vanguard letter of intent, the parties discovered that the underfunding of one of the pension plans and the reduction of state budget support required that the transaction terms be modified to shift a portion of the purchase price from the capital commitment to cash.

GWHN and Vanguard submitted a Conversion Application on May 3, 2013 ("Vanguard Application") and later, it submitted CON applications to transfer the imaging ventures. The Office of the Attorney General and OHCA released completion questions which were answered and the application was deemed complete July 1, 2013. Additional

interrogatories were issued by the Office of the Attorney General and OHCA and responded to during the summer of 2014.

In July 2013, Yale New Haven Health System and Vanguard announced an alliance to develop clinical networks as well as a joint venture to acquire substantially all of the assets of Eastern Connecticut Health Network. GWHN executives, investment bankers, counsel and board conducted diligence and again, concluded that it was best for GWHN and the greater Waterbury community for the board to move forward with the transaction with the deal it had made with Vanguard/Tenet.

In October 2013, Tenet Health Care announced that it was acquiring Vanguard. GWHN executives, investment bankers, counsel and board conducted diligence on Tenet and its hospitals. Many of the Vanguard executives continued on in their roles in the successor organization. After GWHN executives, board members and physicians visited two Tenet hospitals, reviewing the diligence provided by their experts, GWHN's board decided to continue the transaction with Tenet.

In the spring of 2014, Tenet Health Care announced it plans to acquire the assets of Saint Mary's Health System, which operates the other hospital in Waterbury. The Board consulted with Cain Brothers and Principle Valuation about the effect of this new transaction and concluded that it continued to be satisfied.

During this time, the Hospital continued to struggle financially. From the date of the Vanguard Letter of Intent (October 2012) and the public hearing in October 2014, the Hospital/Network experienced losses at FYE 2013 and 2014 respectively. In spite of continued financial losses, which resulted in layoffs and continued lack of investment in capital projects, the Hospital's clinical excellence was recognized nationally by both **US News and World Report** and **HealthGrades**; it was also recognized for a third time as a "Most Wired Hospital" by the American Hospital Association.

On October 15, 2014, a public hearing was held in Waterbury; additional interrogatories and post hearing production requests were issued and the applicants completed them. Navigant Consulting, Inc. ("Navigant") was engaged as a consultant to the regulators in reviewing the Conversion Application; Navigant representatives conducted extensive diligence on the transaction with site visits by several representatives, extensive diligence requests, interviews with GWHN executives, counsel and its board chair over several months. Navigant's thorough report was released publicly and totaled over one hundred (100) pages. It concluded that all of the statutory conditions, including those relating to the Board's diligence in deciding to undertake the transaction, the selection of the fairness opinion expert satisfied the statutory requirements of Section 19a-486 et. seq. On December 1, 2014, decisions were issued by the Office of the Attorney General and the Office of Health Care Access. A number of conditions were place on the transaction. On December 11, 2014, Tenet withdrew the Vanguard Application and announced that it would no longer pursue transactions within the State of Connecticut. Shortly thereafter, the Hospital announced additional layoffs.

REGROUPING.

GWHN's task force met very quickly after Tenet announced its withdrawal from Connecticut. There were a number of meetings among Tenet and hospital representatives and government officials aimed at bringing Tenet back to the table but ultimately these were unsuccessful.

The Task Force requested Cain Brothers to re-canvass the market for prospective partners. There was a strong sentiment that the Tenet decision had made Connecticut unappealing for for-profit entities and, in fact, informal outreach efforts revealed this to be the case. In addition to for-profit systems, there were some exploratory conversations with two academic medical centers but ultimately no paths forward were identified with these centers.

During the first quarter of 2015, the Task Force met a number of times with its advisors and kept the GWHN Board apprised of its activities. Three out of state for profit candidates contacted Cain Brothers and indicated their interest in Waterbury Hospital; two submitted proposals. After studying these proposals, the Task Force presented the two proposals to the Board.

Key Features of 2015 Proposals

	Prospect	**Candidate #2**
Form of Transaction	Asset purchase.	Asset Purchase
Total Unadjusted Transaction Value	$100 million	$90 million
Cash Proceeds to Foundation	TBD	TBD
Net Foundation Assets	TBD	TBD
Long Term Capital Commitments	Minimum of $55 million over a 7- year period.	Minimum of $55 million over a 5-year period.

Governance	• Anticipated a local board to be created consisting of local community leaders and physicians. • Would rely on current board members, or a subset thereof, to comprise the new board.	Silent
Continuation of Services	Anticipated maintaining essential clinical services for 5 years.	Silent
Assumption of Pension Liabilities	Yes	Silent
Timing	Not explicitly provided.	30-45 days due diligence prior to signing a Definitive Agreement.
No Sale Provision	5 years.	Silent
Right of First Refusal/Repurchase Rights	Did not expect any rights of first refusal or repurchase rights, though open to discussing with GWHN.	Silent
Charity Care	Subject to diligence, would adopt GWHN's charity and indigent care policies.	Silent
Employee Matters	Expected to offer employment to substantially all employees of GWHN, including management team.	Silent

GWHN's board was already very familiar with Prospect since the Task Force interviewed Prospect in 2012 at the time that Vanguard (Tenet) was considered. Despite GWHN's declining financial performance, at the Task Force's direction, Cain Brothers was able to negotiate a deal with Prospect that was similar to the proposed Tenet transaction. Candidate #2's proposal was insufficiently developed in the eyes of the Task Force. The candidate had not completed any transactions. The Task Force reviewed and approved Prospect's proposed letter of intent and

reported favorably on it to the GWHN Board at a Special Meeting on April 29, 2015. The Board adopted a resolution authorizing the execution of the letter of intent with Prospect and, on May 1, 2015, a letter of intent was executed.

After the execution of the letter of intent, both parties commenced diligence. A group of GWHN board members and physicians visited Prospect hospitals in Rhode Island as well as Prospect headquarters in California where they learned more about Prospect's "coordinated regional care" population health management. They reported to the full Board that they were satisfied that Prospect would serve the community's needs.

In addition, GWHN counsel provided a memorandum under attorney client privilege that summarized certain reverse diligence material provided by Prospect.

The GWHN Board reviewed the Transaction during a Special Meeting on September 21, 2015. At this Special Meeting, the GWHN Board adopted resolutions approving the Transaction, the filing of the CON and recommending to the GWHN Members that they approve the Transaction. The GWHN Members approved the Transaction at a Special Meeting on October 2, 2015. The GWHN Members' approval included authorizing the GWHN Board to take all action necessary or convenient to the consummation of the Transaction, together with such modifications to the Transaction that the GWHN Board in its reasonable discretion may deem appropriate.

For a discussion of the diligence in obtaining the fairness opinion, please refer to Question 7.
For a discussion of the specific terms of the Asset Purchase, please refer to Question 2.

6. **Describe any and all potential conflicts of interest between, among, or pertaining to, at a minimum, any and all board members, officers, key employees, and experts of GWHN, PMH, any other party to the transaction, and any person or entity that performed assessments requested in this application. In addition, describe the due diligence taken to determine the existence of any conflicts of interest, including how GWHN and PMH defined "conflict of interest" for purposes of the response to this question.**

Response:

GWHN

GWHN and Prospect both prepared and disseminated a Conflict of Interest/Financial Disclosure form (the "Disclosure") to (i) board members, (ii) experts consulted with respect to the Transaction, and (iii) senior executives who have direct involvement in the Transaction. The Disclosure required respondents to disclose any financial, beneficial and/or employment interest in the Transaction and/or in any entity affiliated with the parties to the Transaction. The Disclosure also required statements regarding Related Persons, defined as follows:

"A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or

marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent."

The completed Disclosures for GWHN are attached hereto as **Exhibit Q6-1**. Several of the GWHN Board members are physicians employed by the Hospital or an affiliate and the Hospital's CEO is a voting member of the GWHN Board. As of August 11, 2015, Dr. David Pizzuto, a GWHN Board member and Hospital employee became the chair of the independent physician association ("IPA") recently formed by Prospect. The IPA is an initial step in developing Prospect's coordinated regional care network.

Prospect

PMH has no conflict of interest with the proposed transfer of certain assets of GWHN to Prospect between, among or pertaining to its board members, officers, key employees or experts. The due diligence undertaken by Prospect to determine that there is no existence of a conflict of interest included the collection of Disclosures from the relevant individuals. Disclosures were disseminated in September, 2015 to those individuals who are Prospect board members, experts and consultants retained by Prospect, as well as senior executives at Prospect who have direct involvement in the Transaction. Copies of the Disclosures completed for Prospect are attached hereto as **Exhibit Q6-2.** In addition, a copy of Prospect's Code of Business Conduct is set forth in **Exhibit Q6-3**.

7. Provide an assessment of the fair market value of the transaction, including, but not limited to, a discussion regarding whether the fair market value of GWHN's assets has been manipulated. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment. Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

Response:

Principle Valuation, LLC ("Principle") performed the Fairness Evaluation for GWHN's proposed transaction with LHP in 2010 and Vanguard/Tenet in 2013 as well as those for Saint Mary's Hospital's and Bristol Hospital's transactions with Vanguard/Tenet in 2013 and 2014. Principle has more experience in the local market than any other firm. GWHN became familiar with Principle when it conducted two RFP's for a Fairness Evaluation in 2011.

In early September, 2011, the GWHN Board sent an RFP to three firms for the purposes of obtaining a Fairness Evaluation for the LHP Joint Venture pursuant to C.G.S. 19a-486a(c)(5). A copy of the RFP is set forth in **Exhibit Q7-1**. Only one firm responded, so it was determined that the search should be expanded so that the Board had multiple proposals to

consider. The RFP was distributed to a larger group of firms in early October 2011 and GWHN received three additional proposals.

After careful consideration and interviews with the responders, the GWHN Board selected Principle to perform the Fairness Evaluation for the LHP Joint Venture. Principle's qualifications and conflict disclosures are fully articulated in their RFP response in 2011 located in **Exhibit Q7-2.** All proposals received are attached as **Exhibit Q7-3.** Updated biographies of the individuals working on the Fairness Evaluation, as well as updated qualifications are attached as **Exhibit Q7-4**.

Based on these factors, the GWHN Board again decided to retain Principle to provide a Fairness Evaluation of the proposed transaction with Prospect. Principle's compensation is a flat non-contingent fee. The GWHN Board believes that Principle has unique knowledge and experience in the Waterbury market, as well as non-profit/for-profit ventures, which will result in a time and cost efficient engagement. In performing the evaluation, Principle considered the value of the GWHN assets being transferred against the value of benefits received from a financial point of view. The review also considered the economic benefit to be provided by the Hospital to the community through its teaching programs and community benefits programs. Principle utilized three valuation methodologies to assess the value of the assets being transferred: Cost Approach, Market Approach and Income Approach. The Income Approach was used to assess the value of benefits received by the *Foundation as a result of the transaction*, including the inherent value associated with continuation of the teaching programs and community benefits programs.

Assessment activities and analytics undertaken by Principle include:

- Visited site to assess overall condition of physical assets and improvements;
- Reviewed CIM prepared by Cain Brothers;
- Reviewed business and financial information pertaining to GWHN prepared subsequent to the CIM;
- Reviewed financial statements prepared by GWHN that project the future performance of GWHN should the transaction not occur;
- Reviewed offers received by GWHN;
- Reviewed certain available business and financial information related to Prospect;
- Reviewed financial and operating forecasts;
- Reviewed historical market prices, trading activity and valuation multiples of relevant publicly traded companies and used them as benchmarks for the analysis;
- Compared the proposed financial terms of the transaction with other relevant transactions;
- Reviewed the proposed Asset Purchase Agreement by and between GWHN and Prospect;
- Researched relevant market place interest rates for debt and money market instruments; and
- Assessed the general economic market and current monetary conditions.

Assumptions used include:

- In the absence of the transaction, GWHN will likely face increased competition from competitors with access to capital;
- Based on the age and condition of the property, the remaining economic life of the Waterbury Hospital Campus is five years;
- Without the transaction, GWHN earnings and volume will deteriorate while the costs associated with the physical plant increase resulting in marginal to negative cash flows;
- GHWN's current and future negative earnings will restrict it from accessing necessary capital to modernize or replace the facility; and
- In the absence of the transaction, the overall viability of GWHN and its ability to continue its community benefits and teaching programs will be in jeopardy beyond a five year horizon.

Valuation of Assets Contributed

In deriving the value of the assets that Prospect will purchase from GWHN, Principle utilized the Cost Approach (also known as Adjusted Book Value Approach), the Income Approach and the Market Approach. For the Cost Approach, Principle derived a depreciated replacement cost for the tangible assets in use. The Cost Approach is summarized as follows:

Valuation Summary as of August 2015 With Economic Depreciation

WATERBURY HOSPITAL - SCHEDULE 1A
VALUATION SUMMARY AS OF JUNE 2015 WITH ECONOMIC DEPRECIATION

Building/Name	Address	Land Value	Building Depreciated Cost	Land Improvements Replacement Cost	Land Improvements Depreciated Cost	Total Real Estate Value	FF&E	Grand Total
Waterbury Hospital		$ 7,500,000	$ 2,389,000	$ 3,635,718	$ 41,000	$ 9,930,000	$1,517,000	$ 11,447,000
Grandview Building		-	76,000	-	-	76,000	-	76,000
Apartment A & B		-	16,000	-	-	16,000	-	16,000
Baker House		-	15,000	-	-	15,000	-	15,000
72 Hale Street		-	45,000	-	-	45,000	-	45,000
101 Robbins Street		-	21,000	-	-	21,000	-	21,000
36 Grandview Avenue		-	22,000	-	-	22,000	-	22,000
140 Grandview Avenue Suites		-	64,000	-	-	64,000	-	64,000
134 Grandview Avenue Suites		-	39,000	-	-	39,000	-	39,000
TOTALS		**$ 7,500,000**	**$ 2,687,000**	**$ 3,635,718**	**$ 41,000**	**$ 10,228,000**	**$ 1,517,000**	**$ 11,745,000**

Tangible Asset Value Summary

Working Capital	$ 6,800,000
Land	7,500,000
Land Improvements	41,000
Buildings	2,687,000
Equipment	1,517,000
Total Tangible Assets	**$ 18,545,000**
Rounded To	**$ 18,550,000**

In the Income Approach, Principle utilized a Discounted Cash Flow methodology based upon market-based cost of capital considerations, and the limited earning capacity of GWHN should the Transaction not occur. The first Discounted Cash Flow analysis considered the value of GWHN should the transaction not occur, and is as follows:

Discounted Cash Flow GWHN "Stand-Still" - Schedule 1B

Discount Rate	11.00%
Effective Corporate Tax Rate in U.S, CT	39.88%
Normal Debt Free Net Working Capital as % of Revenues	12.00%

	FY 2016 Projected	FY 2017 Projected	FY 2018 Projected	FY 2019 Projected	FY 2020 Projected
NET INCOME FOR DISCOUNTING (EBIT)	$ (5,534,554)	$ (5,359,138)	$ (6,805,959)	$ (4,364,179)	$ (4,473,284)
ESTIMATED INCOME TAXES	(2,207,180)	(2,137,224)	(2,714,217)	(1,740,435)	(1,783,946)
NET INCOME	**$ (3,327,374)**	**$ (3,221,914)**	**$ (4,091,743)**	**$ (2,623,744)**	**$ (2,689,338)**
Less Incremental Working Capital	$ (1,498,772)	$ (408,189)	$ (274,068)	$ (814,793)	$ (835,163)
Less Capital Expenditures	(7,857,143)	(7,857,143)	(7,857,143)	(7,857,143)	(7,857,143)
Plus Depreciation	6,849,701	6,838,400	6,830,365	7,001,124	7,176,152
Cash Flow to Discount	$ (5,833,588)	$ (4,648,846)	$ (5,392,589)	$ (4,294,556)	$ (4,205,492)
Discount Periods	0.500	1.500	2.50	3.50	4.50
Present Value Factor	0.9492	0.8551	0.7704	0.6940	0.6252
Present Value of Periodic Cash Flows	$ (5,536,997)	$ (3,975,215)	$ (4,154,224)	$ (2,980,491)	$ (2,629,441)
Sum of PV Periodic Cash Flows		$ (19,276,368)			
Perpetuity Value	$ 7,700,000				
PV of Perpetuity Value		$ 4,814,346			
Business Enterprise Value Before Adjustments		**$ (14,462,022)**			
Adjustments to Value:					
Less: Market Required Working Capital Balance		$ (29,972,852)			
Add: Working Capital to be Transferred		6,800,000			
Excess/(Deficit) Working Capital		$ (23,172,852)			
Business Enterprise Value After Adjustments		**$ (37,634,874)**			
Rounded Value		**$ -**			

Finally, Principle used two Market Based approaches to estimate the value of GWHN contributed assets: Guideline Company Approach and Guideline Transaction Approach. The following table summarizes the Guideline Company analysis:

Guideline Company Approach - Schedule 1C

Company Name	Share Price 9/1/2015	Adjusted Equity Value[1]	Adjusted Enterprise Value	% Debt	Revenues	EBITDA	Debt Free NWC	% Debt Free NWC	Beta	EBITDA Margin	Revenue Multiple	EBITDA Multiple
Universal Health Services Inc. (UHS)	$ 131.78	14,507,396,640	17,873,881,640	19.64%	8,575,803,000	1,549,172,000	588,455,000	6.86%	1.24	18.06%	2.08	11.54
Tenet Healthcare Corp. (THC)	$ 47.34	5,655,804,480	20,624,804,480	74.96%	17,568,000,000	1,888,000,000	2,352,000,000	13.39%	11.54	10.75%	1.17	10.92
Community Health Systems, Inc. (CYH)	$ 51.60	7,316,467,200	25,110,467,200	70.60%	19,491,000,000	2,853,000,000	2,516,000,000	12.91%	1.01	14.64%	1.29	8.80
HCA Holdings, Inc. (HCA)	$ 84.32	42,010,584,960	73,198,584,960	44.92%	38,429,000,000	7,737,000,000	4,357,000,000	11.34%	0.99	20.13%	1.90	9.46
LifePoint Health, Inc. (LPNT)	$ 75.15	4,004,893,800	6,430,793,800	38.37%	4,963,000,000	627,400,000	868,400,000	17.50%	1.16	12.64%	1.30	10.25
HIGH:			$73,198,584,960	74.96%	$38,429,000,000			17.50%	11.54	20.13%	2.08	11.54
LOW:			$6,430,793,800	19.64%	$4,963,000,000			6.86%	0.99	10.75%	1.17	8.80
AVERAGE:				49.70%				12.40%	3.19	15.24%	1.55	10.19
MEDIAN:				44.92%				12.91%	1.16	14.64%	1.30	10.25

(1) Adjusted upward 20% to account for a control premium
(2) Information from Yahoo Finance and SEC annual and quarterly reports.

Waterbury Hospital 0.5%

Qualitative Comparisons (Subject Compared to Market Comparables as a Group)

Unit of Comparison	Status	Adjustment
Size of Company	Inferior	Downward
Diversity of Market Served	Inferior	Downward
EBITDA Margin	Inferior	Downward
Overall Adjustment	**Downward**	

Waterbury Hospital

Description	Revenues	EBITDA
Adjustment	**-70%**	**-60%**
Adjusted Multiple*	**0.389**	**4.100**
Subject Comparable Units	**$ 265,912,096**	**$ 1,315,147**
Value Indication	**$ 103,366,463**	**$ 5,392,055**
Weighting	40%	60%
Total Asset Value as Unencumbered and assuming market based working capital (Rounded)	**$44,600,000**	
Market Required Working Capital Balance	$ (29,972,852)	
Actual Working Capital Balance	$ 6,800,000	
Less: Deficient (Excess) Working Capital	**$ (23,172,852)**	
Business Enterprise Value	**$ 21,427,148**	
Overall Value Rounded	**$ 21,400,000**	

In the Guideline Transaction Approach, Principle examined 24 recent transactions as follows:

Transactions of Hospitals with Net Losses

Facility	State	Sale Date	Reported Price	Number of Beds	Revenues	Earnings	Price/Revenue Adjusted (1)	Price/Bed	Earnings Lost/Revenues
Monroe Hospital	IN	10/20/14	$2,000,000	132	$41,936,686	($23,129,002)	0.05	$15,152	-55.2%
Two Kansas Hospitals	KS	3/1/13	$54,300,000	232	$184,802,677	($8,780,678)	0.29	$234,052	-4.8%
Lakeside Women's Hospital	OK	1/1/13	$21,900,000	61	$39,194,023	($5,014,932)	0.56	$359,016	-12.8%
New York Westchester Square Medical Center	NY	12/1/12	$14,000,000	140	$75,679,000	($2,400,000)	0.18	$100,000	-3.2%
New England Sinai Hospital	MA	4/1/12	$37,000,000	212	$74,300,000	($3,700,000)	0.50	$174,528	-5.0%
Christ Hospital	NJ	3/1/12	$43,500,000	227	$125,100,000	($4,600,000)	0.35	$191,630	-3.7%
Satilla Health Services	GA	3/1/12	$51,000,000	231	$152,800,000	($540,000)	0.33	$220,779	-0.4%
Cumberland River Hospital	TN	2/1/12	$6,750,000	36	$11,100,000	($520,000)	0.61	$187,500	-4.7%
Decatur General Hospital	AL	2/1/12	$25,000,000	242	$113,500,000	($1,500,000)	0.22	$103,306	-1.3%
Parkway Medical Center	AL	12/1/11	$37,800,000	109	$45,300,000	($1,500,000)	0.96	$346,789	-3.3%
Virginia Regional Medical Center	MN	12/1/11	$27,000,000	164	$50,700,000	($1,200,000)	0.61	$164,634	-2.4%
Louisianna Medical Center and Heart Hospital	LA	10/3/11	$23,000,000	137	$50,400,000	($37,500,000)	0.52	$167,883	-74.4%
Person Memorial Hospital	NC	6/1/11	$22,700,000	102	$41,600,000	($394,000)	0.63	$222,549	-0.9%
Hospital of Saint Raphael	CT	3/1/11	$135,000,000	511	$450,300,000	($7,200,000)	0.34	$264,188	-1.6%
Two Chicago Suburban Hospitals	IL	8/1/10	$45,000,000	569	$267,372,825	($30,444,778)	0.19	$79,086	-11.4%
Sparks Health System	AR	12/1/09	$138,200,000	510	$258,162,282	($23,592,914)	0.62	$270,980	-9.1%
Banks Jackson Commerce Medical Center	GA	12/1/09	$7,100,000	90	$45,160,355	($818,931)	0.18	$78,889	-1.8%
Medina General Hospital	OH	4/1/09	$50,000,000	118	$88,900,000	($1,300,000)	0.65	$423,729	-1.5%
Wadley Health System	TX	2/1/09	$21,000,000	370	$95,074,879	($8,068,172)	0.25	$56,757	-8.5%
Palmetto Health Baptist Easley	SC	1/1/09	$50,000,000	109	$84,400,000	($4,500,000)	0.68	$458,716	-5.3%
St Francis Hospital & Health Center	IL	7/1/08	$65,000,000	309	$158,171,473	($15,567,027)	0.47	$210,356	-9.8%
Our Lady of Mercy Medical Center	NY	7/1/08	$38,000,000	369	$207,973,604	($9,265,220)	0.21	$102,981	-4.5%
North Ridge Medical Center	FL	4/1/08	$20,000,000	332	$90,484,054	($39,786,982)	0.25	$60,241	-44.0%
Saint Clare's Health System	NJ	4/1/08	$145,800,000	655	$240,552,031	($6,959,774)	0.70	$222,595	-2.9%
						Average	**0.43**	**$196,514**	**-11.3%**
						Median	**0.41**	**$189,565**	**-4.6%**
						High	**0.96**	**$458,716**	**-0.4%**
						Low	**0.05**	**$15,152**	**-74.4%**

(1) Adjusted Pre-2012 Sales Upward by 15% to Account For Bad Debt Reporting Change

Greater Waterbury Health Network		
	Revenue	**Beds**
Projected 2016	$ 265,912,096	357
Selected Multiple	0.20	$ 60,000
Indicated Value	$ 53,182,419	$ 21,420,000
Weighting	50.0%	50.0%
Overall Indication Before Adjustments		**$ 37,300,000**
Plus: Debt-Free Net Working Capital		**$ 6,800,000**
Overall Value Derived (rounded)		**$ 44,100,000**

And lastly, in considering the value of GWHN assets transferred, Principle reviewed the only other bid received by GWHN. Principle then determined a final estimate by weighting the various strengths and weaknesses of each approach. The following schedule illustrates the weighting and values.

Greater Waterbury Health Network
Summary and Conclusion of Assets to Transfer

		Indicated Value	Weighting	Weighted Contribution
Adjusted Book Value Approach	Schedule A	$18,550,000	60%	$11,130,000
Discounted Cash Flow Approach	Schedule B	$0	0%	$0
Market Based Approaches				
Guideline Company Approach	Schedule C	$21,400,000	15%	$3,210,000
Guideline Transaction Approach	Schedule D	$44,100,000	25%	$11,025,000
Total Weighted Value of Assets Transferred				**$25,400,000**

Principle calculates the value of GWHN assets to be transferred at $25,400,000.

With regard to the fair market value of assets, Principle found no indication of manipulation by any person in a manner that causes the value of the assets to decrease.

Please refer to **Exhibit Q7-5** for supporting schedules.

8. Provide an assessment of whether the transaction will place GWHN's assets, including but not limited to Waterbury Hospital, at unreasonable risk. Provide copies of all documents and statements, financial and otherwise, in support of this assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

Response:

The transaction will not place the assets of the Hospital at unreasonable risk. The acquired assets are not being pledged to fund their purchase. Prospect is a $1.3 billion revenue healthcare organization and has the financial capacity to provide the capital necessary for the Transaction. The value of the benefits received by GWHN exceeds the value of assets purchased by PMH. Please see Applicants' response to Question 6, the Fairness Evaluation attached as **Exhibit Q7-5**, the 2014 audited financial statements for Prospect attached in **Exhibit Q8-1** and the 2015 2nd Quarter unaudited financial statement for Prospect attached in **Exhibit Q8-2**.

9. **Provide an assessment of whether any managerial contracts to be entered into are for reasonable fair value. Provide copies of the managerial contracts and of all documents and statements, financial and otherwise, in support of the fair value assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.**

Response:

It is not currently anticipated that there will be a management contract between Prospect and GWHN as of the closing. A future management contract, if any, would be for reasonable fair value.

10. **Describe the entity to which the fair market value of GWHN's assets will be transferred, including the funding of the entity, its corporate structure, governance and membership, and the charitable purpose of the entity. Provide copies of documents related to the creation, structure, and purpose of the entity.**

Response:

THE CONCEPT OF THE FOUNDATION

THE FUNDING OF THE INDEPENDENT FOUNDATION

It is not currently anticipated that there will be significant proceeds from the Transaction after providing for the various liabilities of GWHN and its affiliates. Subject to the approval of the Attorney General, and if appropriate, the Superior Court, certain charitable assets will be transferred to a newly formed tax exempt entity (the "Independent Foundation"). This entity will seek qualification as a 501(c)(3) charitable organization. To the extent not required for the satisfaction of the liabilities of GWHN, the net amount of "Indemnification Holdback," described in the APA (see **Exhibit Q3-2**, Section 10.09 of the APA), would also be paid over to the Independent Foundation. The assets of the Independent Foundation will also include short term investments, marketable securities and certain assets whose use is limited by donors and/or held in trust.

As required by statute, the Independent Foundation will be independent from both Prospect and GWHN. It will not be part of the corporate structure of either Prospect or GWHN and its directors will not be employees or directors of Prospect, GWHN or any affiliates thereof. The Independent Foundation will have no members (as that term is defined in the Connecticut Revised Nonstock Corporation Act) and will be governed by a Board comprised of at least 9 but not more than 12 directors. Factors to be considered in selecting the directors of the Independent Foundation will include knowledge of the Hospital's service area, skill set, work experience, the diversity of the individual's cultural background, ethnicity, gender, age, and socioeconomic status. During their term of service and for one year after the completion of their service, directors of any Prospect entity or GWHN entity may not serve as directors of the Independent Foundation. Similarly, employees of any Prospect entity or any GWHN entity may not serve as directors of the Independent Foundation. The Board of the Independent Foundation shall be self-perpetuating.

THE CHARITABLE PURPOSE

As part of the planning process for the formation of the Independent Foundation, representatives from GWHN have studied similar foundations in other communities. While each of these organizations shares a common purpose, each is unique in that it has been designed to meet the specific needs of its community. The charitable purpose of the Independent Foundation will be to support the health care needs of the Greater Waterbury community, including preventative health care and health care education. The Independent Foundation will not fund the charitable obligations of the post-closing Hospital.

Drafts of the Independent Foundation's proposed Certificate of Incorporation and Bylaws are included in **Exhibit Q10-1** and **Exhibit Q10-2**, respectively.

11. Identify any and all assets of GWHN that are subject to a charitable use restriction imposed by a donor and the intended handling of those assets as a result of the proposed Asset Purchase. Please provide a listing of these assets in Microsoft Excel format. Also, please provide copies of the original gift instruments for each gift identified. Only one hard copy of the gift instruments needs to be produced to the Attorney General.

Response:

An analysis of the gift instruments is found in **Exhibit Q11-1** and the charitable assets of the Hospital are delineated in the table below. Copies of the original gift instruments are attached as **Exhibit Q11-2.**

The Hospital is the entity that holds or benefits from the charitable assets. After the closing of the proposed transaction, the Hospital will continue its existence until its liabilities existing as of the closing date are satisfied. The Applicants anticipate that the Hospital will continue to receive the income from its unrestricted funds, and the unrestricted income it

receives from trusts held by third parties (including those trusts with specific gift over provisions that may take effect in the future after the Hospital dissolves; also including, as to excess income only, those funds that distribute excess income to the Hospital beyond that amount required to provide free care for certain classes of individuals, and that it will use such unrestricted income as the primary source of payment for the Hospital's liabilities. Once all these liabilities are satisfied, and The Waterbury Hospital is dissolved, an approximation action or construction action, as the case may be, will be required with respect to the unrestricted funds held by the Hospital and the unrestricted income received by the Hospital from trusts held by third parties. These actions will determine whether the Foundation will receive the assets and/or income after the Hospital's dissolution or if the assets or income will be paid over to others after the Hospital's dissolution, in order to satisfy the intent and directions of the original donors. An approximation action will also be required with respect to all the restricted assets (including bed funds) held by the Hospital in order to determine whether the Foundation will receive those assets and/or income or whether the assets or income will be paid over to others, in order to satisfy the intent and directions of the original donors.

Following is a list of categories of funds held by or for the benefit of the Hospital:

UNRESTRICTED ENDOWMENT FUNDS

The Lamb, Forester, Hallden and Brooker endowment funds are unrestricted endowments. They have "income only, for general purposes of the Hospital" language that is not deemed to be a restriction on use of principal under the Uniform Prudent Management of Institutional Funds Act ("UPMIFA") and do not require that the funds be used for any specific purpose. Because the Lamb, Forester, Hallden and Brooker funds have no specific, restrictive donor language that under the applicable statutes would prohibit the use of the funds for general purposes, they are classified as unrestricted endowment funds.

RESTRICTED ENDOWMENT FUNDS

These endowment funds were established by gift instruments that set forth the intent of each donor. Use of these funds is in accordance with the donors' instructions.

THIRD PARTY TRUSTS

The majority of charitable assets are held for the benefit of the Hospital by third-party trustees who remit income payments to the Hospital. Most recurring trust income payments are remitted to the Hospital for its general purposes; some are paid to the Hospital for specific purposes, such as dispensary funding, scholarships, research and other specific Hospital purposes. The Hospital does not have control over the expenditure of the principal of the outside funds, but rather has a permanent beneficial interest in the income. The Hospital also has a number of future vested and contingent interests under certain third party trusts.

MISCELLANEOUS FUNDS

The Hospital is frequently named as the recipient of bequests under decedents' wills; currently a bequest from the Estate of Molly Patricia Lenners is pending in Probate Court. If this bequest is received prior to the closing of the proposed transaction, it is directed to be paid directly to the Hospital without restriction. In addition, the Hospital has a Charitable Gift Annuity Program that it offers donors, in which charitable contributions are held subject to the payment of current income to the donors, with principal being distributed to the Hospital only after the death of a donor and all named income recipients.

PERMANENT BED FUNDS

Many gifts have been made by donors to the Hospital, for the specific purpose of providing a free bed or establishing a free bed fund for the benefit of patients who cannot otherwise afford treatment at the Hospital. These funds are restricted bed funds and are held in a consolidated Bed Fund account. The income from this fund is used to pay for charity care of patients at the Hospital as directed by the donors. Other bed funds have further donor restrictions as to the group of patients who are to be considered or given preference in making distributions and so are held separately. Certain other restricted bed funds are held separately from the consolidated Bed Fund because they were directed to be named after the donor or a relative of the donor. Finally, as noted in the beginning section of this response to Question 11, income from certain funds is used first for free care as directed by the donor, and all excess income from those funds is then directed by the donor to be distributed to the Hospital as unrestricted income for its general uses and purposes. It would be anticipated that the Hospital will continue to receive only the unrestricted portion of the income from that category of funds to be used toward payment of the Hospital's debts and liabilities.

GENERAL ENDOWMENT FUND

The Hospital's General Endowment Fund consists of gifts given outright to the Hospital for its general use and purposes, without any restrictions as to the use of either income or principal. The General Endowment Fund therefore is not an endowment under UPMIFA, but rather is classified as "Board Designated". This fund is fully expendable by the Hospital.

The table below lists the charitable assets by classification as of July 31, 2015.

TYPE OF FUND*	**ASSET VALUE 7/31/15**
Waterbury Hospital Unrestricted Use Schedule A Part 1	$658,203
Waterbury Hospital Restricted Use Schedule A Part 2	$1,464,463
Third Party Trusts Schedule B	$38,070,121
Miscellaneous Schedule C	$638,540
Permanent Bed Funds Schedule D	$18,104,810
General Endowment Fund Schedule E	$1,914,232
**	
TOTAL	**$60, 850,369**

*See Attached Schedules A-E, Table of Trusts and Other Gifts

**Outright gifts and gifts allowed to be used in full by the Hospital that have in fact been fully expended in accordance with the terms established by the donors have not been included in the analysis.

The Hospital has conducted a thorough review of all of the charitable assets and made an exhaustive search for supporting documentation. The Hospital has been able to locate nearly every gift instrument after diligent attempts to acquire information. However, no further records of these funds could be located:

- Curtis, Mary A. Bed Fund – Schedule D – this fund was created under the Will of William E. Curtis. His Will could not be located. Searches were conducted at the Connecticut State Library, the Waterbury Probate Court and Silas Bronson Library Archives. The Connecticut State Library located three decedents by that name but did not have information regarding the town of death. Probate Courts were contacted in Naugatuck, which also covers Middlebury; Litchfield; and Region #22, which covers Bethlehem, Oxford, Roxbury, Southbury, Washington, Watertown and Woodbury;

- Fitzsimmons, Louis E. – Schedule D – this fund was created under the Will of Mary E. Fitzsimons, who died on October 9, 1934 in Waterbury. Her Will could not be

located. Searches were conducted at the Connecticut State Library, the Waterbury Probate Court and Silas Bronson Library Archives. Probate Courts were contacted in Naugatuck, which also covers Middlebury; Litchfield; and Region #22, which covers Bethlehem, Oxford, Roxbury, Southbury, Washington, Watertown and Woodbury;

- Marguerite B. Fulling – Schedule A – this fund was created under an Inter Vivos Trust, which is not public record. The law firm that handled the matter no longer exists and the attorney is deceased; the successor law firm has no record of the Fulling Trust;

- Burdsall, Margaret and Burritt, Harriett Bed Funds and Burritt, Edith & Melrose Bed Fund – Schedule D – both of these funds were created under the Will of Edith Porter Burritt, who died on July 4, 1926. Her Will could not be located. Searches were conducted at the Connecticut State Library, the Waterbury Probate Court and Silas Bronson Library Archives. Probate Courts were contacted in Naugatuck, which also covers Middlebury; Litchfield; and Region #22, which covers Bethlehem, Oxford, Roxbury, Southbury, Washington, Watertown and Woodbury; and

- Swenson, John – Schedule D – his Will could not be located. Searches were conducted at the Connecticut State Library, the Waterbury Probate Court and Silas Bronson Library Archives. The Connecticut State Library located three decedents by that name but did not have information regarding the town of death. Probate Courts were contacted in Naugatuck, which also covers Middlebury; Litchfield; and Region #22, which covers Bethlehem, Oxford, Roxbury, Southbury, Washington, Watertown and Woodbury.

12. Provide copies of all correspondence, memoranda, and any other documents that include the terms of any other offers to transfer assets or operations or change control of operations received by the Hospital.

Response:

Please see **Exhibit Q12-1**.

13. Provide a copy of a fairness evaluation by an independent person who is an expert in such Asset Purchases that includes the expert's evaluation of each of the criteria set forth in Conn. Gen. Stat. § 19a-486c(a). Also provide copies of the information and documents relied upon by the expert in the preparation and issuance of the fairness evaluation.

Response:

Please see Fairness Evaluation and supporting schedules in **Exhibit Q7-5.**

14. Please provide a copy of the transcript for the informal hearing required by Conn. Gen. Stat. § 19a-486a(c).

Response:

Please see **Exhibit Q14-1**.

15. Explain how GWHN determined the need for the Asset Purchase and discuss the benefits of this Asset Purchase for Waterbury Hospital (the "Hospital") (provide discussion on history and time-line).

Please see the answer to Question 5 with respect to how GWHN determined the need for the Asset Purchase.

The Asset Purchase will benefit the Hospital in numerous ways. Significantly, the transaction will provide the post-closing Waterbury Hospital and GWHN's other provider organizations access to capital and resources necessary to sustain and grow high quality medical services in its service area. In addition, the transaction will allow the post-closing Hospital and affiliates the ability to adjust to a rapidly changing healthcare delivery environment and reinvest in itself to continuously improve care coordination, address continued improvement in quality and safety, expand and add needed services, recruit and retain physicians, and improve access to services across its service area.

The benefits of this transaction will inure to the post-closing Hospital's entire network, including Waterbury Hospital and GWHN's other affiliates. GWHN's mission to improve the well-being of its patients by providing high quality, compassionate care involves healthcare provided in settings across the network continuum. To effectively participate in the evolving risk-based payment environment, health systems must manage across a complete continuum of care in order to deliver services in the right place at the right time. This transaction will allow the post-closing Hospital and affiliates the ability to rebuild and retool itself for the new world of accountable health care delivery. Prospect's experience in its CRC model which will enable the post-closing Hospital and affiliates to be successful with new risk-based payment systems and new care delivery models that reward value-based care, achieving the best outcomes for patients at lower costs. With the resources and the intensive care management programs of Prospect and the commitment to implementing its CRC model in the local service area, not only will the post-closing hospital see reinvestments, but will be positioned to continue to integrate and expand its network of providers and program offerings. Development of ambulatory services, such as an ambulatory surgery center, coupled with the post-closing Hospital's position and clinical integration in partnership with its medical staff, will bring the numbers of covered lives needed to be successful in developing and executing programs to manage population health.

Prospect has access to the capital markets that will make capital available to GWHN for replacements and upgrades to systems and the infrastructures of GWHN's facilities; investments to improve the sharing of electronic medical records in order to improve the collection and documentation of information and, most importantly, to enhance the availability of information for critical treatment decisions for our patients; upgrades to the medical equipment and technology to provide its patients access to state-of-the-art technology for their diagnosis, care and treatment; and program development to attract and retain physicians to the communities served.

The Transaction will bring clinical strength and leadership to augment clinical programs. The intent of the Transaction is to develop local access to services where it is clinically appropriate.

Prospect offers economies of scale and purchasing power to reduce the cost of operations which will improve finances and help ensure the sustainability of the post-closing hospital. This benefits GWHN's Service Area as well. The financial health of the post-closing hospital and its affiliates will allows them to offer continued levels of employment that are critical to the health of the local economy. Prospect has also agreed to fully assume the pension benefit plans of the GWHN employees. As important, the Asset Purchase will mean that Prospect will continue to adhere to the same policies with respect to charity care for at least the first 5 years after Closing.

16. Provide a listing of the Hospital's current service lines and service locations and describe any planned changes to either the service lines or service locations as a result of the Asset Purchase. Provide an explanation for each change and detail how the hospital's affiliation with PMH will aid in service line development.

Response:

The following are the service lines offered by the Hospital. Unless otherwise noted, these services are provided on the Hospital campus. At present, no changes in the service lines or locations are planned as a result of the Asset Purchase. Also, please see **Exhibit Q16-1** for the Supplemental CON Application form for the Acquisition of Equipment related to CT scanners at the Hospital.

Behavioral/Mental Health

- Mental health clinic (located at 88 Grandview Avenue) including child and adolescent (ages 12 -18) services, adult and gero-psychiatry services
- Ambulatory Chemical Detox
- Substance Abuse – Day/Evening Treatment
- Inpatient Substance Abuse Treatment
- Substance Abuse – Medical Triage
- Outpatient Substance Abuse Treatment

Cardiology

- Inpatient Cardiac Angioplasty
- Outpatient Cardiac Angioplasty (Hospital)
- Diagnostic Cardiac Catheterization
- Open Heart Surgery
- Diagnostic services including stress testing and Echocardiograms (available at the Hospital and at 455 Chase Parkway the Cardiac Diagnostic Center) and pulmonary Function testing and Cardiopulmonary Rehab (Available only at the Hospital)

Cancer Services

- Inpatient Chemotherapy
- Outpatient Chemotherapy (provided by an affiliate, The Harold Leever Cancer Center)
- Inpatient Medical Oncology
- Outpatient Radiation Oncology (provided by an affiliate, The Harold Leever Cancer Center)
- Inpatient Surgical Oncology
- Outpatient Surgical Oncology

Diagnostic and Imaging Services

- CT Scanning (also available at 134 Grandview Avenue)
- Lithotripsy
- Linear Accelerator (provided by an affiliate, The Harold Leever Cancer Center)
- Mammography
- Nuclear Medicine
- PET/PET-CT (provided by an affiliate, The Harold Leever Cancer Center)
- Ultrasound
- X-Ray

Emergency Department

- Level Two Trauma Services

Family Birthing and Neonatal Intensive Care

- Inpatient Maternity
- Outpatient Maternity
- Level Three nursery

Gastroenterology

- Colonoscopy
- Sigmoidoscopy
- Ileostomy
- Sclera Therapy
- Fecal Implants

- ERCP
- ERCP with Lithotripsy
- Esophageal Stent Placements and Removal
- Panendoscopy
- HALO Procedure
- Enteroscopy
- Esophageal Dilation
- Gastrostomy Placements and Removal

Infectious Disease Clinic

- HIV Primary Care
- HIV Center of Excellence

Intensive/Critical Care

Outpatient Medical Therapies

Primary Care

- Provided by Alliance Medical Group (owned by GWHN) at 8 different locations in the region

Pulmonary Services

Rehabilitation

- Inpatient
- Outpatient (in conjunction with Access Rehab, which has 11 locations in the region)

Surgical Services

- Breast
- Colorectal
- General
- GI
- Orthopaedics
- Urology
- Vascular

Telemetry

17. Describe the existing populations served by the Hospital and how the Asset Purchase will affect these populations. Include demographic information.

Response:

Waterbury Hospital is located in the city of Waterbury near the junction of routes 8 and 84. Service area towns include Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott and Woodbury.

The Hospital's primary and secondary service areas are identified in the following map.

Service Area Demographics

The following table summarizes the service area population projected forward to 2020. The area population is stable and experiencing growth, particularly in the secondary service area.

The city of Waterbury is by far the most populous municipality in GWHN's service area.

Table E: Service Area Population

Total Population by Town 2000-2020			
Town	**2000**	**2012**	**2020**
Beacon Falls	5,246	6,015	6,648
Bethlehem	3,422	3,594	3,711
Cheshire	28,543	29,253	29,120
Middlebury	6,451	7,522	8,471
Naugatuck	30,989	31,795	32,877
Prospect	8,707	9,450	9,864
Southbury	18,567	19,841	20,480
Thomaston	7,503	7,855	8,112
Waterbury	107,271	110,074	115,128
Watertown	21,661	22,449	23,020
Wolcott	15,215	16,638	17,821
Woodbury	9,198	9,925	10,395
Primary Service Area	**264,773**	**276,423**	**287,667**
Harwinton	5,283	5,620	5,779
Morris	2,301	2,469	2,460
Oxford	9,821	12,602	14,714
Plymouth	11,634	12,193	12,789
Seymour	15,454	16,487	17,421
Southington	39,728	43,038	45,136
Torrington	35,202	36,239	37,394
Secondary Service Area	**119,423**	**128,648**	**135,693**
Total Service Area	**384,196**	**405,071**	**423,360**

Source: Connecticut Economic Resource Center Town Profiles (2014)

Table F below arrays population by town and age segment while **Table G** compares age distribution by town to the State distribution. The GWHN service area age distribution is consistent with that of the State of Connecticut as a whole.

Table F: Age Distribution

Age Distribution by Service Area Town 2012							
Town	**0-4**	**5-17**	**18-24**	**25-29**	**50-64**	**65+**	**Total**
Beacon Falls	320	1,091	463	2,042	1,369	730	6,015
Bethlehem	123	548	327	824	1,121	651	3,594
Cheshire	1,250	5,601	2,674	9,456	6,132	4,140	29,253
Middlebury	281	1,414	432	2,294	1,763	1,338	7,522
Naugatuck	2,018	4,783	2,667	11,233	6,827	4,267	31,795
Prospect	408	1,563	833	3,086	2,187	1,373	9,450
Southbury	747	3,442	1,130	4,620	4,517	5,385	19,841
Thomaston	279	1,264	634	2,875	1,693	1,120	7,865
Waterbury	8,118	19,927	11,311	37,951	19,252	13,515	110,074
Watertown	1,168	3,804	1,709	7,055	5,001	3,712	22,449
Wolcott	550	3,204	1,364	5,351	3,559	2,610	16,638
Woodbury	397	1,625	638	2,729	2,878	1,658	9,925
Primary Service Area	**15,659**	**48,266**	**24,182**	**89,516**	**56,299**	**40,499**	**274,421**
Harwinton	159	996	370	1592	1636	867	5620
Morris	86	457	156	777	693	300	2,469
Oxford	742	2,347	884	3,826	3,201	1,602	12,602
Plymouth	561	2,032	1,102	4,054	2,893	1,551	12,193
Seymour	735	2,859	1,608	5,495	3,685	2,105	16,487
Southington	2,243	7,270	2,627	13,753	9,530	7,615	43,038
Torrington	1,975	5,707	2,491	12,179	7,902	5,985	36,239
Secondary Service Area	**6,501**	**21,668**	**9,238**	**41,676**	**29,540**	**20,025**	**128,648**
Total Service Area	**22,160**	**69,934**	**33,420**	**131,192**	**85,839**	**60,524**	**403,069**
Source: Connecticut Economic Resource Center Town Profiles (2014)							

Table G: Percent Age Distribution

Percent Age Distribution by Service Area Town 2012						
Town	**0-4**	**5-17**	**18-24**	**25-29**	**50-64**	**65+**
Beacon Falls	5□	18□	8□	34□	23□	12□
Bethlehem	3□	15□	9□	23□	31□	18□
Cheshire	4□	19□	9□	32□	21□	14□
Middlebury	4□	19□	6□	30□	23□	18□
Naugatuck	6□	15□	8□	35□	21□	13□
Prospect	4□	17□	9□	33□	23□	15□
Southbury	4□	17□	6□	23□	23□	27□
Thomaston	4□	16□	8□	37□	22□	14□
Waterbury	7□	18□	10□	34□	17□	12□
Watertown	5□	17□	8□	31□	22□	17□
Wolcott	3□	19□	8□	32□	21□	16□
Woodbury	4□	16□	6□	27□	29□	17□
Primary Service Area	6□	18□	9□	33□	21□	15□
Harwinton	3□	18□	7□	28□	29□	15□
Morris	3□	19□	6□	31□	28□	12□
Oxford	6□	19□	7□	30□	25□	13□
Plymouth	5□	17□	9□	33□	24□	13□
Seymour	4□	17□	10□	33□	22□	13□
Southington	5□	17□	6□	32□	22□	18□
Torrington	5□	16□	7□	34□	22□	17□
Secondary Service Area	5□	17□	7□	32□	23□	16□
Total Service Area	5□	17□	8□	33□	21□	15□
Source: Connecticut Economic Resource Center Town Profiles (2014)						

Table H below provides data regarding the socioeconomic condition of the GWHN service area in comparison to the State of Connecticut as a whole. The data reveals a diverse array of communities ranging from rural to urban. While several communities in GWHN's service area are relatively affluent, the City of Waterbury struggles with high unemployment and high poverty. As a result, GWHN serves a large Medicaid and uninsured population. In FY2015, Medicaid recipients accounted for more than 28% of the Hospital volume and Medicare almost 47%. Uninsured individuals accounted for nearly 2% of the Hospital inpatients and nearly 4% of outpatients. Central Waterbury is designated by the Health Resources and Services Administration as a Medically Underserved Area as well as a Health Professionals Shortage Area. The Asset Purchase by PMH will provide the cost savings and access to capital necessary to maintain a safety net hospital in Waterbury and recruit additional physicians and midlevel providers. After the Asset Purchase, the Hospital will continue to treat individuals regardless of their ability to pay.

Table H: Socioeconomic Status of the Service Area.

Socioeconomic Data				
Town	**Poverty Rate**	**Medium Household Income**	**Unemployment Rate**	**Medium Age**
Primary Service Area				
Beacon Falls	3.8%	$ 79,207	7.0%	39
Bethlehem	4.4%	$ 80,884	5.8%	50
Cheshire	2.8%	$ 110,587	6.2%	41
Middlebury	2.6%	$ 97,996	5.9%	45
Naugatuck	8.6%	$ 62,574	9.4%	39
Prospect	3.2%	$ 95,325	6.7%	44
Southbury	6.4%	$ 67,195	6.6%	50
Thomaston	2.7%	$ 67,426	7.8%	43
Waterbury	21.9%	$ 40,867	12.5%	35
Watertown	3.4%	$ 80,899	7.7%	44
Wolcott	3.4%	$ 80,655	7.8%	44
Woodbury	4.6%	$ 80,167	5.9%	48
Secondary Service Area				
Harwinton	4.6%	$ 89,429	6.1%	47
Morris	5.6%	$ 89,688	6.4%	45
Oxford	4.5%	$ 107,308	6.0%	43
Plymouth	6.7%	$ 73,603	8.9%	41
Seymour	6.8%	$ 73,099	7.7%	42
Southington	3.6%	$ 78,668	6.4%	44
Torrington	11.2%	$ 50,548	8.5%	43
State	**10.0%**	**$ 69,519**	**7.8%**	**40**

GWHN and Prospect are committed to ensuring the long-term future and viability of GWHN and the Hospital. No service line or service location changes are currently planned in connection with the Transaction. The Applicants will continue to provide care to residents in the communities that are currently served by GWHN. Given this, the Applicants do not anticipate any changes to the populations to be served by the Hospital.

Using the GWHN Community Health Needs Assessment (see response to Question 22) and other planning information available to GWHN, Prospect will work with management to identify programs and services that best augment those currently provided in the community. In addition, Prospect may have the ability to attract and retain certain types of specialty physicians to a community hospital setting that GWHN may not be able to attract on its own. For example, Prospect may utilize one or more physician alignment strategies, such as physician participation in an IPA or physician-hospital organization, hospital-based clinics staffed by an independent contractor physician and pay-for-performance compensation arrangements which incentivize quality, patient satisfaction and improved patient outcomes. Please note that while the Applicants expect Prospect to expand and enhance services, there are no definitive plans at this time to add service locations for Waterbury Hospital. Prospect will conduct a planning effort with input and recommendations from the Local Board post-Closing to determine where there are opportunities to improve access, enhance services and introduce programs that address identified health needs.

18. How will the for-profit nature of PMH affect the provision of health care in the community?

Response:

There is no correlation between a hospital's tax status and the quality of care, charity care and other benefits provided to the community that it serves. Prospect's tax status will have no negative bearing on the provision of health care in the community. The opportunity represented by this application affords the greatest opportunity for GWHN to enhance financial stability, make needed capital investments and increase the quality and access to care for the entire community.

Prospect's financial resources, access to capital and expertise in operating thirteen hospitals in California, Texas and Rhode Island will positively affect the provision of healthcare in the community. Prospect's capital and access to capital will mean that GWHN will have the financial resources to purchase new technology, upgrade its facilities, attract skilled providers, and upgrade electronic health records. In addition, Prospect will introduce practices that will reduce costs and improve care by sharing its best practices. Access to health care will be improved through implementation of CRC. (Also see response to Question 19, below, regarding a transition plan for the Asset Purchase, and the discussion of CRC in response to Question 26.) Moreover, the post-closing for-profit entity will pay property taxes to the applicable municipalities, which will benefit the community (note that Prospect will seek abatement of local property taxes for a transition period after the

closing). The conversion will also result in the establishment of the Independent Foundation, an independent charitable entity.

In summary, Prospect's tax status will have no negative bearing on the provision of health care in the community. Prospect's financial resources and operational expertise will, however, have a positive impact. In fact, and as evidenced in California, Texas and Rhode Island, where Prospect has acquired hospitals, the access and quality of care improved, significant capital investments were and are continuing to be made, and job growth has occurred.

19. Provide a transition plan for the Asset Purchase and describe how GWHN and PMH (collectively, the "Applicants") will ensure continuity of care and hospital services through this plan.

Response:

The approach to the transition is segregated into four phases of implementation: (1) execution of immediate cost efficiencies; (2) development of clinical efficiencies; (3) deployment of a strategic capital plan; and (4) implementation of CRC. The four phases will be implemented concurrently and in a coordinated fashion.

Prospect has already begun implementation efforts with respect to its CRC model, including formation of an IPA and board with local representatives, review of regulatory requirements, discussions with payers and evaluation of the care delivery network.

A meaningful long-term integration plan requires the collaboration of the medical staff and the community. Clinical efficiencies will be captured as Prospect has the opportunity to fully engage with the medical staff of the Hospital and the Hospital's respective communities to jointly develop a clinical strategy to best serve the populations described in response to Question 17.

The strategic capital plan is formulated to complement the clinical strategy. After closing, Prospect will seek the input of the Local Board to prioritize capital projects and service improvements based on hospital and community needs.

20. Understanding that the proposal is for PMH to exercise ownership over the Hospital, how will care be coordinated care between the Hospital and its various affiliates? Please explain in detail how care coordination efforts will be aided by the proposed Asset Purchase (i.e., how they will be different from GWHN's present efforts). Provide any written plans documenting this coordinated approach to care for the patient population served.

Response:

The care coordination efforts will be aided and greatly enhanced through implementation of Prospect's CRC model. The proposed Transaction will provide the post-closing hospital access to capital and funding necessary to provide even greater access to high quality medical services for the Waterbury region. It will provide the post-closing hospital assurance that it will be able to execute a long range strategic plan that addresses continued improvement in quality and safety, expansion of services, new services, physician and service integration, and improvements in access to services.

The more important goal for the post-closing hospital and Prospect is not just the coordination of care within its hospital but across all providers in its network: owned, affiliated and contracted. The Prospect CRC Model is predicated on building and managing a tightly integrated, coordinated care system with providers across the continuum. Prospect's thirty years of operating and supporting IPAs under risk-based arrangements with payers in California allows Prospect to bring its process knowledge and experience to build and operate such a system here. Prospect will engage the insurers and seek partnerships with them that will result in a full range of risk contracts for post-closing hospital system. Risk management unifies the incentives for providers across the network. It will be essential to identify patients with significant co-morbidities and then design comprehensive medical and psychosocial high intensity care management services for their care. This is some of the process knowledge and experience that Prospect will bring to the region for the benefit of our patients. Importantly, the CRC model is designed to demonstrate and improve performance with a focus not only on hospital value-based purchasing measures, but the criteria used by government agencies to assess health plans and their participating providers who contribute to patient care and health management for a population of individuals.

21. Provide a description of the relationship between the proposal and the Statewide Health Care Facilities and Services Plan.

Response:

The proposal is consistent with the Statewide Health Care Facilities and Services Plan (the "Plan") published by OHCA in October of 2012 and supplemented in 2014. The Plan can be found on OHCA's website.[4] The Transaction is clearly aligned with the premise of the Plan. The applicants believe that this proposal supports the goals and addresses all of the guiding principles set forth in the Plan. Section 1.4 of the Plan states:

> "The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health

[4] Connecticut Department of Public Health, Statewide Health Care Facilities and Services Plan, October 2012, http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/ohca_statewide_facilities_services_plan_2012.pdf ; Statewide Health Care Facilities and Services Plan, 2014 Supplement, http://www.ct.gov/dph/lib/dph/ohca/publications/2014/final_2014__facilities_plan_-_2_24_15.pdf.

services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage collaboration among health care providers to develop health care delivery networks;
- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;
- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state." (the Plan at p. 2).

As the Plan makes clear, OHCA has long acknowledged that mergers, affiliations and acquisitions were part of a transformation that had begun as the State's health care system responded to major changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5). Becoming part of a health care system such as Prospect will aid the post-closing hospital and its provider affiliates to benefit from economies of scale when purchasing supplies and services, share best practices and improve access to capital. This will allow the post-closing hospital to make capital investments and reinvestments in its

facilities, equipment, and in medical and information technology to support needed programs and services for patients. These investments will in turn allow the post-closing hospital to attract and retain physicians and providers needed to serve its communities.

As OHCA has recognized in the Plan, the strategic financial and quality of care advantages associated with the affiliation or mergers of hospitals and health care providers is a key driver in today's health care environment. Connecticut hospitals are pursing affiliation arrangements and mergers as a means of offsetting financial pressures due to the provision of uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients and reduced reimbursement by the government payers and health insurers. Hospitals are struggling to make needed facility improvements and acquire needed technology. (Plan at pp. 7-8, Sec. 1.8.5 and pp. 11-12, Sec. 2.1.1). This proposal serves as an example of this trend. The implementation of the proposal will allow GWHN and its provider affiliates to better meet their financial obligations, make needed capital improvements, acquire new technology and continue to provide continued access to services currently available in the surrounding communities.

By entering into the Transaction, GWHN and its provider affiliates will be able to fulfill GWHN's obligations, including retiring its debt, and funding its pension plan. As a result, the post-closing hospital will be better positioned to expand cost control initiatives in community-based settings, and remain a lower-cost, high-quality provider for the patients in its service area.

More important to residents now served by GWHN, the transaction with Prospect will result in stronger integration between the post-closing hospital and its provider affiliates to coordinate care, improve the overall population health and enhance the standard of care for its patients. The Prospect approach to care coordination with the pursuit of delegated risk-based provider contracts aligns the incentives for providers across a system. Shared risk requires that a system achieve a more formal degree of integration among providers than the traditional fee-for-service system. It unifies the incentives for providers. Risk drives an imperative to manage care proactively for a defined population by understanding the health of that population, identifying those who require more intensive care management and, importantly, addressing unmet healthcare needs and gaps in care. (Plan at pp. 81-83, Sec. 7.1, 7.2). Opportunities to further integrate care delivery among the post-closing hospital system's providers and regionalize the health care delivery system in the GWHN service area will be enhanced, to more effectively identify patients at risk and build upon existing initiatives. Prospect has developed and implemented high intensity care management programs that integrate behavioral and physical health capabilities to effectively manage the care of patients with significant co-morbidities. It will bring those capabilities to the greater Waterbury community along with other resources to meet the health care reform requirements of the Patient Protection and Affordable Care Act of 2010 (the "PPACA").

PPACA requires hospitals to improve quality of care delivered to patients through a variety of means such as reducing preventable readmissions for certain conditions. (Plan at pp. 12-13, Sec. 2.1.2, 2.1.3, 2.1.4., 2.1.4.2 and 2.1.4.3). Prospect is committed to succeed in new

value-based performance delivery models and has the ability to share best practices among its member hospitals to reduce readmissions. This proposal promotes population health management, which is a system that seeks a very high level of integrated care among providers to work collaboratively along the health care continuum, emphasize health promotion and the delivery of preventive and medically necessary care. Population Health Management promotes collaboration among providers and the development of a continuum of care where providers are more closely aligned and work in a cohesive environment. Prospect's CRC model will provide an environment that aligns physicians and other providers across the continuum of care, provide access to evidence-based practices to improve quality and patient safety, enhance efficiency through uniform productivity and financial management, and develop integrated information systems.

22. Please explain how the post transaction GWHN will address the needs of service area residents with respect to prevention and treatment of diseases and conditions in relation to the Hospital's most recent Community Health Needs Assessment ("CHNA") and the priority of needs listed therein. Please provide a copy of the most recent CHNA.

Response:
In 2013, Waterbury Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. It is attached as **Exhibit Q22-1**. The CHNA was done in collaboration with the Greater Waterbury Health Improvement Partnership. The partnership consists of Waterbury Hospital, Saint Mary's Hospital, Waterbury Department of Public Health, City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way and other community organizations. Waterbury Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The CHNA Implementation Plan, in **Exhibit Q22-2**, provides detail how Waterbury Hospital is implementing the recommendations of the CHNA. In sum, the CHNA identified the following key priority areas for the greater Waterbury Community:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Smoking/Tobacco Use

Waterbury Hospital has a number of programs and initiatives addressing each of these priorities. They include:

Access to Care:
Waterbury Health Access Program improves access to high-quality medical care by providing comprehensive case management, pharmacy assistance, and access to primary and sub-

specialty medical care for the uninsured and underinsured residents of the Greater Waterbury region. This program, and Waterbury Hospital in particular, was recognized nationally as a model for helping to enroll individuals in the first round of enrollments in the state's Health Insurance Exchange.

- Waterbury Hospital Infectious Disease Clinic, which offers a comprehensive model of care and treatment for people living with AIDS/HIV.
- Be Well Bus, which provides free transportation to/from the hospital and medical appointments in the community.
- Medical Education (through Internal Medicine Residency programs and other clinical training)
- Waterbury Hospital Youth Pipeline Initiatives
- Providing Early Acquaintance with Careers in Healthcare (PEACH)
- Parent Leadership Training Institute
- Parents Supporting Educational Excellence
- Waterbury Hospital Summer Bridge Program

Mental health/substance abuse:

- Waterbury Hospital is one of the region's largest providers offering a full continuum of behavioral health services for children, adolescents, and adults. Services are provided inpatient and on an outpatient basis.

Overweight/Obesity:

- Nutritional counseling
- Employee and patient fitness initiatives
- Surgical weight loss center under development
- Community-based initiatives with other partners to promote healthy living through improved nutrition and increased physical activity.

Smoking/Tobacco Use:

- Tobacco screening is provided to all behavioral health patients who are tobacco users
- Smoking cessation programs, for employees and the community

Another CHNA, to be completed by September 2016, is already under discussion with plans to launch this initiative by January 2015 and presentation/approval by 2016.

The APA commits Prospect to maintain and adhere to the GWHN's current policies on charity care for at least 5 years from Closing. At all times while the Prospect affiliate owns and operates the post-closing hospital, it will continue to provide charity care in accordance with applicable law, and will continue to provide medically necessary services to the surrounding communities currently served by GWHN. Prospect is also required, for at least the first 5 years after Closing, to "provide public health programs of educational benefit to the community," and "generally promote public health, wellness, and welfare to the

community by operating the Hospital with quality standards consistent with other hospitals owned by [Prospect], subject, in each case, in all respects to changes in governmental law, policy or regulation." (See **Exhibit Q3-2**, Section 6.09 of the APA.)

Support from PMH in implementing strategies to address priority needs:
Prospect will continue to focus efforts on improving population health, including effective strategies for improving access to mental health services, substance abuse treatment and reducing the incidence of obesity, smoking and tobacco use, heart disease, cancer and diabetes in the surrounding communities. PMH will utilize its experience and knowledge in population health management to enhance the efforts previously identified by the Hospital in its original Implementation Plan, and incorporate best-practice recommendations for disease prevention, early detection screenings, and treatment options within each of the priority areas.

Prospect will support the priority needs identified by the CHNA with a variety of physician alignment and population health management strategies, enhanced through Prospect's implementation of CRC, which focuses on the health of vulnerable populations.

23. Provide a description of plans that the Applicants will implement to control cost, such as discharge care coordination, implementation of electronic medical records and emergency department triaging to the appropriate level of care. In responding to this question, report any anticipated savings from the following expense categories for the Hospital: salaries and wages, fringe benefits, contractual labor fees, medical supplies and pharmaceutical costs, depreciation and amortization, bad debts, interest expense, malpractice expense, utilities, business expense and other operating expenses.

Response:

The specific anticipated savings are presented by expense category in response to Question 37 and described in response to Question 38.

Prospect manages costs by eliminating inefficiency and reducing unwarranted variation in the delivery of patient care services. The CRC model promotes the efficient operation of hospitals by aligning physician interests with the efficient and effective delivery of healthcare. Prospect's delivery model rewards physicians for quality and outcomes, not outputs, through shared savings and pay-for-performance standards and benchmarks. Its delivery model of integrating physicians, hospital and health plans to population and performance management is proven in three markets in Southern California, Texas and Rhode Island. Prospect has demonstrated improved clinical outcomes, higher quality scores, higher patient satisfaction, lower re-admission rates, lower average lengths of stay, and lower medical-cost ratios. With leadership and input from the Local Board, Prospect will use its delivery model to engage physicians and strengthen their alignment with GWHN.

24. Provide a description of the Applicants' plans to continue to provide services to the uninsured and underinsured. In responding to this question, please describe any changes to the Hospital's current charity care, uncompensated care and financial assistance policies and procedures, and hospital bed funds that will result from the Asset Purchase. Describe any plans Applicants have to work with other providers in the community, such as federally qualified health centers or community health centers, to provide specialty care to patients, or low cost programs that the Applicants will provide in the area that are tailored toward the uninsured or underinsured.

Response:

Pursuant to Section 6.09 of the draft APA (see **Exhibit Q3-2**, Section 6.09), Prospect will do the following:

- Ensure that the post-closing hospital maintains and adheres to GWHN's current policies on charity care for at least five (5) years after the closing date, subject to changes in applicable law and other legal requirements or governmental guidelines or policies;

- For as long as Prospect owns and operates the hospital, operate the post-closing hospital's charity care program in accordance with applicable law, other legal requirements and governmental guidelines and policies, and continue to provide medically necessary services to the surrounding communities served by GWHN;

- For a period of at least five (5) years after the closing date, (i) participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, (ii) accept all emergency patients without regard to ability to pay, (iii) maintain an open medical staff, (iv) provide public health programs of educational benefit to the community, and (v) generally promote public health, wellness, and welfare to the community by operating the post-closing hospital with quality standards consistent with other hospitals owned by Prospect, subject, in each case, to changes in governmental law, policy or regulation;

Prospect will actively work with other providers in the Hospital's service area such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the service area, including Medicaid recipients. Also see response to Question 26 regarding how the transaction will improve quality, accessibility and cost effectiveness of health care delivery.

25. Submit a list of all key professional, administrative and clinical department heads related to this proposal. Additionally, provide a copy of the Curriculum Vitae of each individual listed.

Response:

GWHN

GWHN's Administrative and Clinical Department Heads include the individuals listed below. Curriculum Vitae for each are included as **Exhibit Q25-1**.

Darlene Stromstad, President and Chief Executive Officer
Michael Cemeno, Vice President and Chief Information Officer
David J. Pizzuto, M.D., Vice President of Medical Affairs/Chief Medical Officer
Mark Holtz, Senior Vice President and Chief Operating Officer
James Moylan, Interim Chief Financial Officer
John Camus, Vice President Physician Practices (Alliance Medical Group/Waterbury Hospital)
Sandra A. Iadarola, R.N., Chief Nursing Officer/Vice President of Patient Care Services
Richard P. Kropp, Ed.D., Vice President for Human Resources
Patricia Gentil, Compliance and Privacy Officer

PMH

Prospect's Administrative and Department Heads are listed below. Biographical summaries for each are included as **Exhibit Q25-2**.

Samuel S. Lee, Chief Executive Officer
David Topper, President of Alta Hospitals System, LLC
Mitchell Lew, M.D., President
Stephen O'Dell Senior Vice President, Coordinated Regional Care
Steve Aleman, Chief Financial Officer
Ellen J. Shin, General Counsel and Secretary
Cindra Syverson, Chief Human Resources Officer
Von Crocket, Senior Vice President, Corporate Development
Hoyt Sze, Chief Compliance & Privacy Officer

26. Provide evidence as to how the Asset Purchase will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons.

Response:

a. After the Transaction closes, Medicaid recipients and indigent persons will have the same access to high quality services. It is anticipated that, over time, Prospect will achieve improvements in access and the quality of services available to will improve.

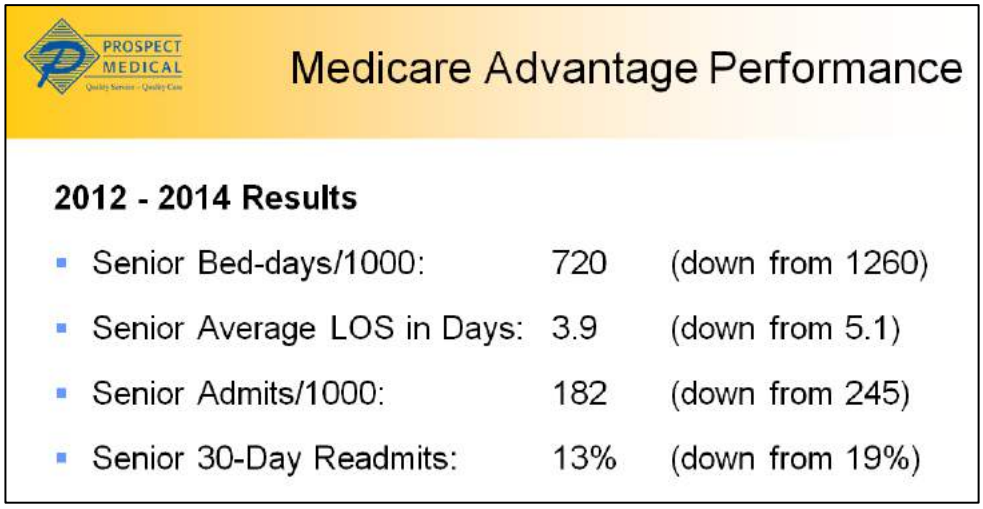
Prospect and GWHN representatives have already met with leadership for Connecticut's Medicaid Program and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. Prospect is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state.

b. Prospect's vision for Connecticut is to have strong and quality-driven hospitals with a robust network of aligned physicians operating from its CRC platform. Prospect will develop its CRC model for the communities served by GWHN by working with payers and physicians. Its experience with CRC in all of its other markets has allowed Prospect to attract more primary care providers and improve access to care. Prospect builds regional networks with its hospitals and medical groups that contribute to the entire continuum of care. In its development of the network in the Greater Waterbury area, it will partner with the medical staff to address gaps in care and services to ensure the effective management of all patients across the network.

c. Prospect has a proven track record of effectively managing risk, capitation and bundled payments for its hospitals and medical groups, while at the same time delivering cost-effective, quality care. Prospect manages the provision of healthcare services to approximately 260,000 members through its network of over 8,900 primary care physicians and specialists. Its hospitals manage the care of 30,000 capitated Medicaid beneficiaries.

The CRC model allows Prospect to respond to the rapid changes in reimbursement and care delivery by operating its hospitals efficiently, aligning physician interests with the efficient and effective delivery of healthcare, and offering a full continuum of non-acute services in the hospitals' service areas. The goal is to ensure that patients receive the right care, at the right time, in the right setting, while avoiding unnecessary, inefficient and duplicative services and reducing medical errors. Prospect is proud of its results. For example, from 2012 to 2014 in California and Texas where Prospect participates in HMO contracts for seniors, Prospect has reduced hospital beds days per thousand from 1,260 to 720. Length of hospital stay for this population has been reduced from 5.1 days to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. (See below.) Prospect recognizes that the delivery of care varies from region to region, and while the same results may not be achieved here, Prospect is confident that improvements in these areas can be achieved to contribute to the cost effectiveness of care for the patients it serves.

Medicare Advantage Performance following CRC Implementation

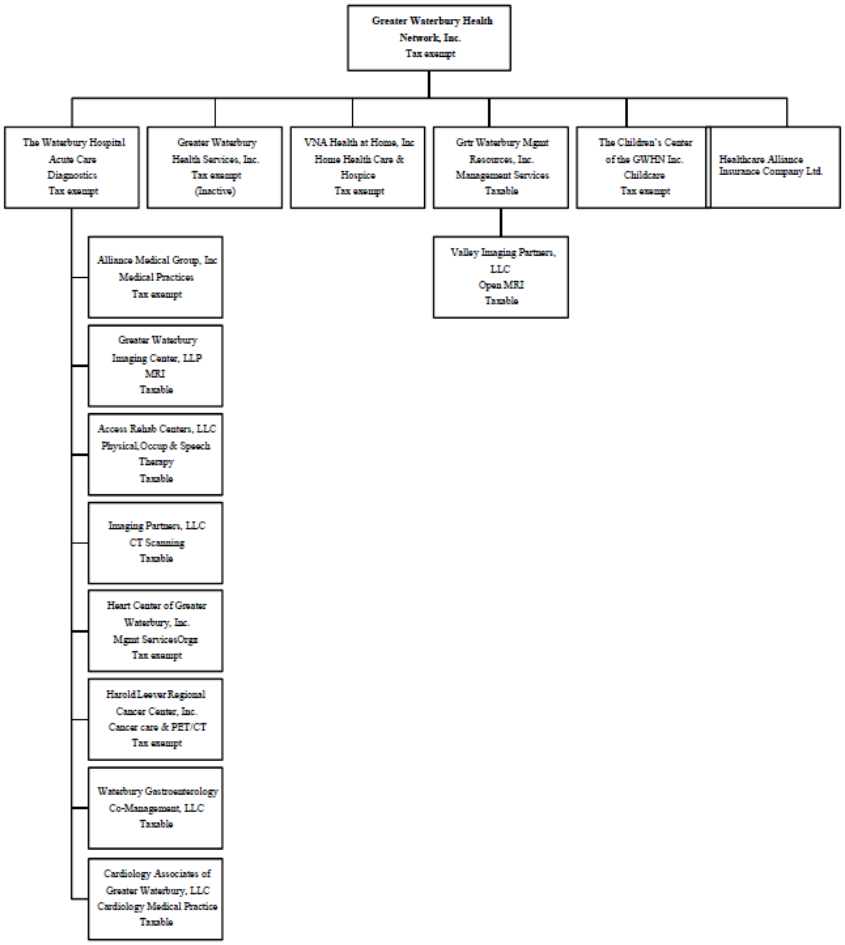


27. Provide the corporate organizational chart prior to and after the proposed Asset Purchase, including all affiliates. For the organizational chart that depicts the post-Asset Purchase structure, working upward on the chain of ownership from the Hospital, please: (i) describe the nature of the ownership and control that each entity has in the entity directly below it; (ii) describe the major business activities/functions of each entity; (iii) provide the principal place of business address for each entity; and (iv) provide the name and business address of each individual currently serving as a member of the governing body of each entity.

Response:

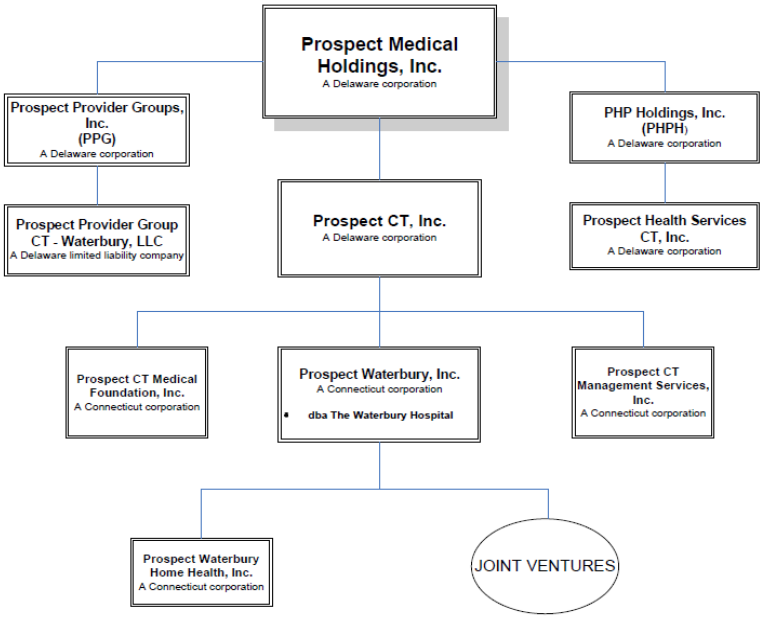
ORGANIZATION CHART OF GWHN

Set forth below is GWHN's organizational chart prior to the Transaction.



ORGANIZATIONAL CHART OF PMH

Set forth below is Prospect's organizational chart after the Transaction.



(i) The nature of ownership and control is reflected in each organizational chart.

(ii) The major business activities and functions of the post-closing entities will mirror those of the corresponding pre-closing entities.

(iii) The principal place of business address for each entity will not be known until the entities have been formed.

(iv) The name and business address of each individual currently serving as a member of the governing body of each entity will not be known until the entities have been formed.

Other Related Entities
Prospect will maintain a medical foundation that will employ physicians and other healthcare care providers from each of the health systems acquired in Connecticut.

28. Please provide the date on which the Hospital filed audited financial statements with OHCA. Applicants may reference these statements in responding to questions. In addition, provide a copy of PMH's most recent audited financial statements.

Response:

GWHN's 2014 audited statements were electronically filed with OHCA on 2/27/15 and a hard copy was filed on 2/28/15 with annual OHCA filing.

A copy of Prospect's most recent audited financial statements are set forth in **Exhibit Q8-1**.

29. List all funding or financing sources for the $100,000,000 in project costs (the "Project Costs") estimated for this acquisition by PMH. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Response:

Prospect has access to an existing corporate level credit facility in addition to its cash on hand. There is no financing contingency with respect to this transaction. The Applicants anticipate that Prospect would fund this acquisition (after giving effect for the assumption of liabilities), by using its existing cash.

With respect to the future capital commitments, the Applicants anticipate that such commitments would be funded through the operations of the post-closing hospital network (if it generates sufficient cash flow at the time of expenditures), Prospect's existing cash at the time of expenditure or, if necessary, Prospect's corporate level credit facility. Details, such as interest rate, term, and monthly payment amounts, do not apply to this Asset Purchase.

30. Indicate whether PMH has developed a plan to invest in facility improvements, general upgrades and renovations, deferred maintenance, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff at the Hospital (a "Capital Plan"). If yes, please provide a copy of the Capital Plan.

Response:

a. There is not a capital plan related to the Transaction at this time. Post-Closing, Prospect, in consultation with the Local Board, will develop a strategic capital plan with respect to the post-closing hospital, affiliates and joint ventures.

b. Routine capital expenditures for facility improvements extend the useful life of the plant. Examples would include replacement of infrastructure/engineering system components such as boilers, electrical switchgear, elevator upgrades, or heating-air conditioning-ventilation units.

Non-routine capital expenditures would result in new technology or improvements to a facility that allow for new or expanded uses. Examples of non-routine facility improvements would include the addition or expansion of a clinical unit that would provide for a new service to be offered such as those made to house a wound care program with hyperbaric chambers, or adding additional birthing rooms to accommodate a growth in demand for obstetrical services or the development of an ambulatory surgery center in response to changing reimbursement schemes.

Deferred maintenance items involve maintenance activities, system upgrades, or repairs that are deferred to a future budget cycle or postponed until funding becomes available. Deferred maintenance most often involves routine capital expenditures as described above. Other examples of items that may be deferred or postponed could include replacements of equipment such as a computer server or installation of new finishes to an area within the facility.

31. Please describe the extent to which the Project Costs related to this proposal may be adjusted for each of the following:

a. outstanding indebtedness;
Response: The outstanding indebtedness for CHEFA bonds and the interest rate swap with Citizen's Bank will be paid at the closing with cash.

b. pension liabilities;
Response: The difference between the assets and liabilities for the CHCA Nurses Pension and the Hospital Cash Balance Plan will be deducted from the $53M sales price.

c. retiree health benefits;
Response: There are no retiree health benefits. Therefore, there is no impact.

d. captive insurers;
Response: Reported medical malpractice and general liabilities will remain the responsibility of GWHN's captive insurance company. Prospect will assume all

medical malpractice liabilities which were incurred but not reported prior to the closing.

e. capital leases;

Response: Prospect has agreed to assume up to $6.5M of capital lease obligations at Closing; any amount in excess of such $6.5M will be deducted from the Capital Commitment.

f. asbestos abatement;
Response: The asbestos abatement liability on the books currently at $2.8M will be subtracted from the sales price.

g. joint venture interests that may not transfer.
Response: The parties have agreed to work together to seek to convert such joint ventures to for-profit entities so that Prospect can take ownership of GWHN's interest in such joint ventures. Therefore it is presently anticipated that the interests will transfer as of the closing.

32. How, if at all, will non-approval by any of the joint venture interests referred to in Question 31(g) above affect the Asset Purchase?

Response:

As described above in 31(g), it is presently anticipated that all joint venture interests will transfer to Prospect as of the closing. If GWHN is unable to transfer some or all of the joint venture interests prior to the closing because of its inability to obtain the required consents form its joint venture partners, the purchase price will be reduced to reflect the value allocable to the joint venture interest not transferred at closing.

33. Please explain in detail the terms of any Capital Plan and in particular:

a. how funds will be allocated for these purposes, including any projected annual amounts;

b. the capital projects for the Hospital that are deemed top priorities by the Applicants;

c. the service improvements for the Hospital that are deemed top priorities by the Applicants;

d. a list of capital projects and service improvements that are expected to be carried out within the first three years following the closing date; and

e. discuss the ability of GWHN to address items listed in subsections 31(b) and 31(c) without the approval of this proposal.

Response:

Greater Waterbury Health Network		
Capital Plan		
Facility – Main Campus		
Expansion of ED/Development of urgent care	$3.75-$M	24-36 months
Upgrade OB/Women's health	$2M	6-18 months
Upgrade outpatient surgery	$2M	6-18 months
Equipment		
Replace interventional radiology equipment	$1.7M	12-18 months
Upgrade surgical/anesthesia equipment	$1.5M	12-18 months

Outpatient Centers

1. Southbury
2. Naugatuck
3. Waterbury

Conceptually discussed for freestanding multi-use outpatient centers, no dollars assigned

Physician recruitment
No dollars yet assigned, immediate

Information Technology

1. Continue IT plan
2. Implement outpatient/physician practice strategy

No dollars yet assigned, immediate

Unless the Transaction is completed, these projects cannot be accomplished.

34. Describe in detail how this proposal will affect the financial strength of the State's health care system and will be financially feasible.

Response:

The financial strength of the State of Connecticut's health care system will be improved with this proposal as it will lead to a stronger and more financially secure post-closing health system for the greater Waterbury community. Connecticut's hospitals and their affiliated hospital networks are an important part of the State's health care system. The financial strength of Connecticut's hospitals significantly contributes to the financial strength of the

State's entire health care system. Financially strong hospital systems can provide access to new and innovative services and improve access to necessary services. Increased access to needed heath care services reduces the burden on State resources and improves the health status of the community.

The proposal anticipates a more fully integrated health care system utilizing Prospect's CRC model which offers resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace. Prospect will bring the strength of its CRC model to the service area of GWHN and provide innovation and a level of integration that GWHN could not possibly do independently. In order to offer high value health care and participate in the emerging value-based payment models, an essential focus of health care reform, providers across the continuum must establish new relationships, infrastructure and capabilities to provide cost efficient care. Significant investments are necessary for health systems to develop new competencies, process skills and knowledge. Examples include, but are not limited to: development and management of an advanced, comprehensive care continuum delivery network; population health management with the identification of those patients requiring high intensity care and sophisticated care management programs; actuarial and health economics data analytics; and integrated information technology, which few small hospital systems can afford. This proposal will allow the greater Waterbury community to benefit from the process skills and knowledge that allow clinical integration and coordination of care. The CRC model promotes efficiency that Prospect has developed over decades of participating in hospital operations by aligning physician interests with the efficient and effective delivery of healthcare, and offering a full continuum of non-acute services in the hospitals' service areas. The goal of the CRC model is to ensure that patients receive appropriate care, at the appropriate time, in the appropriate setting, while avoiding unnecessary, inefficient and duplicative services and reducing medical errors.

The Hospital's capital needs are significant and must be addressed in order to offer the latest technology and competitive facilities. Physical plant renovations are constantly required just to keep hospitals in good working order. For many hospitals, such as Waterbury Hospital, capital needs are large and cannot be met with current avenues for funding.

Prospect offers both financial strength and health care experience. Prospect is prepared to make the necessary investments, and has the financial resources to pay for this investment. These investments will strengthen GWHN, an integral part of Connecticut's health care system. The proposal is financially feasible, and will add to the strength of the State's health care system.

35. Please provide the current payer mix for the Hospital and the projected payer mix for the Hospital after the Asset Purchase (based on the number of patients, not based on revenue) in the following reporting format:

Response:

Table 1: Patient Population/Payer Mix

Waterbury Hospital
Discharges

	YTD 8/31/2015	Projected FY 2015	Projected FY 2016	Projected FY 2017	Projected FY 2018
Medicare	5,002	5,457	5,312	5,312	5,312
Medicaid	3,021	3,296	3,196	3,196	3,196
Champus	18	19	18	18	18
Total Gov't	8,041	8,771	8,526	8,526	8,526
Commercial	2,527	2,757	2,681	2,681	2,681
Self Pay	113	123	64	64	64
Work Comp	61	67	73	73	73
Total Non Gov't	2,701	2,947	2,818	2,818	2,818
Total	**10,742**	**11,718**	**11,344**	**11,344**	**11,344**

36. Provide the assumptions used to project the patient population/payer mix after the proposed Asset Purchase.

Response:

The current payer mix is based on fiscal year 2015 (October 1, 2014 – June 30, 2015). The patient population mix is not expected to change as a result of the APA. Therefore, we would assume the same patient population mix for the first three years after the acquisition.

37. Please provide one year of actual results and three years of projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

a. **Financial Worksheet (C) – for the Hospital only (not inclusive of affiliates), GWHN and PMH without the CON project (columns 1, 2 5, 8 & 11) with the CON project and incremental to the CON project (remainder columns); and**

b. Submit Financial Worksheet (C) using the same page and print layouts (size, font, page orientation, margins, etc.) as provided by OHCA.

Note that the actual results for the fiscal year reported in the first column must agree with the GWHN and the Hospital's audited financial statements. The projections must include the first three full fiscal years of the project.

Response:

Set forth in **Exhibit Q37-1 is** Financial Worksheet (C) for the Hospital only (not inclusive of affiliates), and for GWHN and PMH without the CON project (columns 1, 2, 5, 8 & 11), with the CON project and incremental to the CON project (remainder columns). Financial Worksheet (C) has been provided using the same page and print layouts as provided by OHCA.

38. Provide the assumptions utilized in developing Financial Worksheet (C) (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense percentage increases, project commencement of operation date, etc.).

Response:

The assumptions utilized in developing Financial Worksheet (C) are included as **Exhibit Q38-1**.

39. Explain any projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of the Hospital and GWHN.

Response:

There are no projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of PMH.

40. Please describe any anticipated change to existing reimbursement contracts with payers (e.g., Medicare, Medicaid, commercial) as a result of the Asset Purchase. Is it assumed in the financial projections that Applicants will willingly negotiate with the payers that GWHN currently has contracts with?

Response:

Prospect will accept all existing contracts with payers and will complete the change of ownership procedures required by commercial payers, as well as the Medicare Administrative Contractor and the Connecticut Medical Assistance Program (Medicaid).

41. Please explain in detail how the proposed Asset Purchase will be able to assure satisfaction of GWHN and/or the Hospital's debt and pension obligations.

Response:

As a result of the Transaction, GWHN's debt and pension obligations will be addressed. At the time of the closing and as permitted thereafter, the purchase price (less adjustments) together with GWHN's cash, investments and debt service reserve funds (but excluding charitable funds not available to satisfy GWHN liabilities), will be used to satisfy GWHN's obligations. The funding gap of the pension plan will be deducted from the purchase price in consideration for assuming this liability.

42. Please address the following regarding staffing at the Hospital by completing "Staffing Attachments I&II."

a. Provide the levels of staffing for fiscal year ("FY") 2015 broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the Hospital;

ii. The same information as provided in subsection (a)(i) above showing the RN to patient ratio only; and

iii. The average nursing hours per patient day (NHpPD) for each department and/or unit of the Hospital (all nursing staff should be included in the calculation of nursing hours).

b. Provide the projected levels of staffing by department and/or unit for the Hospital for the first three (3) full FYs following approval of the Asset Purchase broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the Hospital; and

ii. The same information as provided in subsection (b)(i) above showing the projected RN to patient ratio only.

Response:

Please see **Exhibit Q42-1** for Staffing Attachment I, which responds to Question 42.a, and see **Exhibit Q42-2** for Staffing Attachment II, which responds to Question 42.b.

43. For the Hospital, provide a detailed explanation by department and/or unit as completed by the Applicants in Staffing Attachment I, to reconcile any differences between FY 2015 nursing staff levels and those projected for the first three (3) full FYs following approval of the Asset Purchase.

Response:

The nursing staff levels projected for the first three full fiscal years following the Asset Purchase are projected to remain at FY 2015 staffing levels. Such staffing ratios are estimates based on current circumstances and may be updated as appropriate to reflect Prospect and industry best practices, and which reflect changes in technology, implementation of the CRC model of coordinated care, and other factors related to the delivery of high quality, cost-effective care. Prospect is committed to staffing levels that comply with ratios mandated by Connecticut state law and which take into account patient safety and acuity, employee safety and facility census.

Prospect expects very close to 100% of all employees, including patient care staff, to accept employment with a Prospect affiliate.

44. For the Hospital, describe any other hospital-employed or hospital-contracted staff besides nursing staff (e.g., hospitalists, mid-level providers, therapists, etc.) that were engaged to provide direct patient care at the hospital (collectively, "Ancillary Caregivers") for FY 2015 broken out as follows:

a. The type of Ancillary Caregivers and the department and/or unit to which such staff was assigned;

b. The average number of hours per week that such Ancillary Caregivers provided patient care for the department and/or unit; and

c. For the first three (3) full FYs following approval of the Asset Purchase, the average number of hours per week that such Ancillary Caregivers are projected to

provide patient care for each department and/or unit of the hospital described in subsection (a) above.

Response:

Please see **Exhibit Q44-1** for the completed Ancillary Caregivers Staffing Attachment.

The Ancillary Caregivers Staffing Attachment has been completed for FY 2015 based on the actual worked hours experienced from October 1, 2014 through June 30, 2015.

Regarding the average number of hours per week that Ancillary Caregivers are projected to provide patient care for each hospital department and/or unit during the first three full FYs following approval of the Asset Purchase, please see response to Question 46, below, regarding satisfaction of DPH staffing requirements following approval of the Asset Purchase.

The staffing estimates provided on **Exhibit Q44-1** are based on current circumstances and volume and may be updated as appropriate to reflect PMH and industry best practices, and which reflect changes in technology, implementation of the CRC model of coordinated care, and other factors related to the delivery of high quality, cost-effective care. Staffing of Ancillary Caregivers may eventually shift with the implementation of the CRC model, which is expected eventually to result in changes in patient acuity and relative volumes of inpatient and outpatient services.

45. For the Hospital, provide a detailed explanation by department and/or unit to reconcile any differences between the average number of hours per week that the Ancillary Caregivers described in Question 44 above provided patient care in FY 2015 with those projected for the first three (3) full FYs following approval of the Asset Purchase.

Response:

Ancillary Caregiver staffing levels will be based upon volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, technology and best practice industry benchmarking. Over time, PMH's implementation of clinical integration strategies would be expected to improve efficiency and effectiveness in the allocation of staff.

46. For the Hospital, provide evidence that the proposed staffing for nursing staff and Ancillary Caregivers for the first three (3) full FYs following approval of the Asset Purchase meet all Connecticut Department of Public Health ("DPH") staffing requirements and assure continued access to high quality and affordable health care. Be sure to cite the appropriate DPH regulations and/or other industry benchmarks as applicable.

Response:

Proposed staffing levels for nursing staff and Ancillary Caregivers following approval of the Asset Purchase will comply with DPH staffing requirements as outlined in Connecticut Statute § 19-13-D3(c)-(h).[5] Waterbury Hospital will maintain compliance with this statute and have consistently demonstrated compliance to DPH surveyors as requested.

The specific regulation pertaining to nursing staff ratios is as follows:

Department of Public Health § 19-13-D3(e) Nursing service.

(1) There shall be a competent nurse, licensed in Connecticut, as director of nursing service or an equivalent position, who shall be responsible to the administrator for nursing service in the hospital.
(2) The ratio of patients to registered nurses on duty throughout the hospital shall at no time exceed twenty-five patients or fraction thereof to one registered nurse.
(3) The ratio of patients to all nursing staff, registered nurses, licensed practical nurses and other nursing attendants on duty in the hospital shall not exceed seven patients, or fraction thereof, to one from 7 a.m. to 7 p.m., and fifteen patients, or fraction thereof, to one from 7 p.m. to 7 a.m.
(4) If there is an in-patient obstetrical department, the following shall apply:
    (A) The ratio of all nursing staff to patients for obstetrical services shall be no less than one nurse to each ten patients, or fraction thereof, on the 7am to 3pm shift; no less than one nurse to each fifteen patients, or fraction thereof, on the 3pm to 11pm shift; and no less than one nurse to each twenty patients, or fraction thereof, on the 11pm to 7 am shift;
    (B) there shall be at least one registered nurse on duty at all times. For obstetrical services with a census of twenty or more patients, there shall also be a registered nurse on duty for overall supervision of the unit;
    (C) these ratios shall be calculated without inclusion of newborns or pediatric patients.

With respect to the three full FYs following approval of the Asset Purchase, at a minimum, Prospect will continue to meet DPH staffing requirements for nursing and ancillary caregivers. Staffing levels may also change over time as population health management strategies and techniques are implemented. In the absence of DPH rules or other applicable regulations, Prospect will utilize its own or industry best practices to determine appropriate staffing levels, taking into account the health and safety of patients and employees, patient acuity and overall facility volume.

[5] http://www.sots.ct.gov/sots/lib/sots/regulations/title_19/013d.pdf

47. Applicants are required to provide copies of the most recent CMS statements of deficiencies and plans of correction (CMS Form 2567) for all hospitals owned by PMH. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses. No paper copies required.

Response:

Prospect has provided the most recent CMS statements of deficiency and plans of correction for the Rhode Island hospitals owned by Prospect, as these represent the hospitals most recently acquired by Prospect. A summary of each statement and copies of the related documents have been provided in electronic format only, as requested, in **Exhibit Q47-1.**

Prospect is committed to providing the highest quality care at all of its facilities and networks, as evidenced by the following quality care awards (see below):

Prospect Quality Care Awards

48. Provide a copy of, and describe any changes to, any of the following policies and procedures that will be in place at the Hospital if the Asset Purchase is approved:

a. Hospital collection policies (including charity care and bad debt);

Response: Under the terms of the draft APA, Prospect will ensure that the Hospital maintains and adheres to GWHN's current policy on charity care for at least five (5) years from Closing. (See **Exhibit Q3-2**, Section 6.09 of draft APA.) A copy of Hospital's current collection policies are set forth in **Exhibit 48-1.** There are no planned changes to these policies, except as may be required to comply with new legal or regulatory requirements.

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

Response: The chargemaster is provided to OHCA on a monthly basis. The structure will remain unchanged if the Asset Purchase is approved. The chargemaster is generally adjusted annually for inflation and/or market adjustments.

c. the annual or periodic market rate assessment for the Hospital.

Response: Not applicable.

49. The Hospital has provided OHCA with their annual FY 2015 pricemasters, which were most recently updated for the month of June 2015. With respect to this submission please answer the following:

a. Will the pricemaster change as a result of the Asset Purchase?

Response: No. The pricemaster will not change as a result of the Asset Purchase, but Prospect will conduct periodic reviews of the pricemaster.

b. If so, please identify any anticipated increases or decreases to the pricemaster as a result of the Asset Purchase.

Response: Not applicable.

c. Please quantify the overall percentage increase or decrease in the pricemaster that is anticipated in subsection (b) above and explain the rationale for such change.

Response: Not applicable.

50. Please provide monthly financial statistics reports for the months of April, May and June FY 2015, current month and year-to-date, and comparable period for FY 2014 to OHCA, for the Hospital only, GHWN and PMH with the Application and thereafter on a monthly basis for each month (formatted side by side), until a public hearing in this matter is

held. The following financial measurements/indicators should be addressed in the reports:

Monthly Financial Measurement/Indicators

A. Operating Performance
Operating Margin
Non-Operating Margin
Total Margin
Bad Debt as % Gross Revenue
B. Liquidity
Current Ratio
Days Cash on Hand
Days in Net Accounts Receivables
Average Payment Period
C. Leverage and Capital Structure
Long-term Debt to Equity
Long-term Debt to Capitalization
Unrestricted Cash to Debt
Times Interest Earned Ratio
Debt Service Coverage Ratio
Equity Financing Ratio
D. Additional Statistics
Income from Operations
Revenue Over/(Under) Expense
EBITDA
Cash from Operations
Cash and Cash Equivalents
Net working Capital
Unrestricted Assets
Credit Ratings (S&P, FITCH and Moody's)

Response:

Exhibit Q50-1 contains the monthly OHCA financial statistics reports for April, May, June, July and August of FY 2015, showing the current month and year-to-date, and the comparable period for FY 2014, for the Hospital. FY 2014 financial statistics for the entity which will acquire GWHN (Prospect Waterbury, Inc.) are not available, as the entity does not currently exist and will not be formed unless the Asset Purchase is approved.

51. For the Hospital, provide a copy of its IRS Form 990 for the tax year ending September 30, 2014 and with respect to the amounts listed on each line item within Part 1, Section 7 of Schedule H ("Financial Assistance and Certain Other Community Benefits at Cost"), provide a projected amount for each line item for the first three (3) tax years following the Asset Purchase.

Please note that it is understood that the Hospital will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the Hospital will continue to provide in these community benefit categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to GWHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as GWHN's current policies.

Response:

A copy of the Hospital's Form 990 for the tax year ending September 30, 2014 is attached as **Exhibit Q51-1.**

The proposed transaction will result in the transfer of assets to the Independent Foundation, investment income from which has historically been used, in part, to provide community benefits to the Waterbury area. As described in the answer to Question 10, the Independent Foundation will assess community needs and provide grants and resources to organizations, projects, or activities that promote health, including the health of underserved populations and care to populations that are unable to pay. In addition, PMH will continue to provide financial assistance and community benefits to the Waterbury area. As noted in response to Question 26, PMH will ensure that Waterbury Hospital maintains and adheres to GWHN's current policies regarding charity care, and indigent care.

For the first three tax years following the Asset Purchase, the amounts set forth on such schedule are projected to increase 1% each year based on the assumption that there are no changes in the Medicaid population served or the complement of community benefit programs offered by the hospital.[6]

In addition to the above, PMH will pay sales and property taxes which will benefit the State and the local communities (note, however, that PMH and GWHN will seek abatement from sales and property taxes for a transition period after closing and such abatement is deemed critical to the overall success of the proposed transaction).

[6] Includes estimated amounts for PMH and the Independent Foundation

52. For the Hospital, with respect to the amounts listed on each line item within Part II of Schedule H of the Hospital's IRS Form 990 for tax year ending September 30, 2014 ("Community Building Activities"), provide a projected amount for each line item for the first three (3) tax years following the Asset Purchase. Please note that it is understood that the Hospital will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the Hospital will continue to provide in these community building activity categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to GWHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as GWHN's current policies.

Response:

PMH will continue to provide financial support for community building activities in the Waterbury area. As noted in response to Question 26, PMH will ensure that Waterbury Hospital maintains and adheres to GWHN's current policies regarding charity care and indigent care.

Similar to the amounts projected in the response to Question 51, the spending for Community Building Activities is projected to increase 1% each year and assumes no change in the Medicaid population served or the complement of community benefit programs offered by the hospitals.[7]

The projected spending for the Community Building Activities assumes that the same types of activities and services that were provided in FY 2013 will continue to be offered by PMH for the next three fiscal years and beyond if the proposed Asset Purchase is approved.

In addition to the above, PMH will pay sales and property taxes which will benefit the State and the local communities (note, however, that PMH and GWHN will seek abatement from sales and property taxes for a transition period after closing and such abatement is deemed critical to the overall success of the proposed transaction) .

53. Please discuss whether the Asset Purchase is expected to achieve an improved negotiating position with vendors and/or payers and, if such an improved negotiating position is anticipated, how it will translate into tangible savings for the consumer of health care services. Provide a response that both describes any anticipated improvements in detail and quantifies the expected results for the consumer.

[7] Includes estimated amounts for PMH and the Independent Foundation

Response:

As noted in Applicants' response to Question 26, a primary objective of the Transaction is to allow for a coordinated approach to care. When care is coordinated among the Hospital and community physicians and other providers, the patient population will benefit not only from the perspective of better care and better outcomes, but also from a cost perspective.

Prospect expects its approach to population management services to harness the efficiencies of facilities to enhance care at lower costs. It is anticipated that these cost savings will be passed on to consumers. Moreover, Prospect expects that the Transactions will allow the post-closing hospital system to offer plans in which it assumes financial risk which, with the support of Prospect, it will be in an improved position to assume.

The Applicants expect that for all of the reasons noted above and in the response to Question 20, the Transaction will benefit consumers from a financial standpoint, as GWHN will have a lower cost structure and superior, cost-competitive products than it otherwise would not be in a position to offer.

54. Provide details of plans to be put in place to ensure the proposed health care services provided by PMH adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (For more details on CLAS standards see http://minorityhealth.hhs.gov/Default.aspx#sthash.U320zUXq.dpuf.)

Response:

After the closing, the post-closing hospital will continue to follow the policies and procedures currently in place at the Hospital with respect to Culturally and Linguistically Appropriate Services ("CLAS"), to which the Hospital adheres. The Hospital has updated its policies to ensure it is in compliance with CLAS and is actively working to ensure it is delivering high quality and safe patient care to all populations that come through its doors. The Hospital has launched a Diversity Council, representing the broad culturally diverse group of its employees, who are actively engaged in developing education and training for managers and eventually all employees throughout the system.

The Hospital provides interpreter services and this past year provided 26,000 minutes of interpretation through Language Line. Video conferencing also is available for sign language interpretation. Education on the availability and use of these services is routinely provided to staff.

The Hospital also participates in the Connecticut Hospital Association's Diversity Collaborative and holds educational fairs and celebrations during Cultural Diversity Week. Staff and members of the community are involved in developing and participating in this educational event. Members of the community also have provided education to the management staff, which included the use of educational films on cultural diversity, such as respect and awareness of Lesbian, Gay, Bisexual, Transgender (LGBT) patients. The Hospital is assessing its cultural of diversity proficiency, with the goal of becoming a leader in diversity in the community. The Hospital proudly participates in the community's annual "Gathering" to educate our community on our diversity initiatives.

Prospect has and will continue to adopt and adhere to national CLAS standards with a focus on governance, leadership and workforce that promotes CLAS and health equity through policy, practices and allocated resources; offering language assistance to individuals in their preferred language; and encouraging continuous improvement and accountability through ongoing assessments of post-closing hospital's CLAS-related activities and integrate CLAS-related measures into quality improvement activities.

55. What criteria will PMH use to offer current employees employment post transaction or in any new entities that may be formed as a result of this proposal? For those employees that will be employed post transaction by the Applicants, what is the projected difference in salary for current employees and similarly situated employees at other hospitals operated by PMH in similar markets?

Response:

Prospect or an affiliate will offer employment to substantially all active employees in good standing as of the closing date, subject to the satisfactory completion of Prospect's usual and customary hiring practices, in positions and at salaries at least equal to those then being provided by GWHN and with employee benefits substantially similar to employee benefit plans that are comparable to those offered to similarly situated employees at other hospitals operated by Prospect in similar markets.

56. Please provide information regarding whether any health care providers or insurers have an ownership interest in PMH.

Response:

Prospect shareholders include Jeereddi Prasad, M.D., and Sudathi Jeereddi, M.D., each of whom is a California-licensed physician.

57. Please provide information on the relationship, if any, that PMH's existing medical group segment will have to this proposal.

Response:

Prospect's existing medical group affiliates do not have operations in Connecticut and will not participate in post-closing arrangements related to the Asset Purchase. Post-closing, however, it is anticipated that Prospect Provider Group CT – Waterbury, LLC, and Prospect Medical Systems, Inc., Prospect's CRC subsidiary, will play a significant role in the development, implementation and management of physician-hospital alignment strategies, e.g., through CRC, and will share leadership, best practices, experience and knowledge.

58. Please identify PMH's five (5) most recent acute care hospital acquisitions and, for each acquisition, describe in detail how:

(a) the acquisition improved access to care for the hospital's service area;

(b) the acquisition improved the quality of health care for the hospital's service area;

(c) the acquisition lowered the cost of health care for the hospital's service area; and

(d) with respect to subsections (a) through (c) above, please demonstrate these improvements/cost reductions through benchmarks and other data that are commonly used in the hospital industry.

Response:

Please refer to **Exhibit Q58-1**, which presents detailed information regarding the 2014 acquisitions by PMH of Bellflower Medical Center in Bellflower, California (now known as Los Angeles Community Hospital at Bellflower), Newport Specialty Hospital in Tustin, California (now known as Foothill Regional Medical Center), Roger Williams Medical Center in Providence, Rhode Island, and Our Lady of Fatima Hospital in North Providence, Rhode Island, as well as the 2012 acquisition by PMH of four hospital facilities from Nix Health Care System.

EXHIBIT Q3-1

LETTER OF INTENT, AS AMENDED

10780 Santa Monica Blvd
Suite 400
Los Angeles, CA 90025
Tel (310) 943-4500
Fax (310) 943-4501

April 30, 2015

Via E-Mail

Mr. Carl Contadini, Chairman
Greater Waterbury Health Network
64 Robbins Street
Waterbury, CT 06708

Re: Greater Waterbury Health Network

Dear Mr. Contadini:

Please accept this Letter of Intent related to a transaction in which Prospect Medical Holdings, Inc. ("Prospect") or a designated subsidiary, would acquire the assets of Greater Waterbury Health Network (collectively "GWHN").

Our interest in GWHN is based on its location in a very attractive market, its strong presence and commitment to its local community, its reputation for quality and service, and its significant potential for growth. We believe that this is the right opportunity for Prospect and plan to build upon GWHN's significant achievements as an essential community system in the greater Waterbury service area. We plan to implement our operating model (which we call a Coordinated Regional Care ("CRC")) by developing a healthcare delivery network encompassing the entire continuum of patient care including home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health care related services.

Furthermore, we plan to establish a strong physician network by recruiting additional high quality physicians to GWHN's medical staff and implementing a robust physician engagement model which when fully developed, will allow GWHN to further establish its position as the provider of choice in its current service areas and beyond. It is our vision and mission to build on a quality driven, cost-effective healthcare delivery network in the communities served by GWHN and to support the teaching programs at GWHN.

Please note that Prospect has already engaged Mr. Patrick McCabe of Capitol Strategies Group to assist us with respect to regulatory consents and approvals. We have reviewed the conditions of approval promulgated by both the Attorney General's office as well as Office of Health Care

Access relative to the Tenet transaction. We are already in the process of setting up meetings with the appropriate agencies, regulatory authorities and others regarding potential transactions in Connecticut. Based upon the initial input of Capital Strategies group and others, as well as our successful experience in other states such Rhode Island, we are confident that we will be able to negotiate a satisfactory set of conditions for this transaction.

1. **Assets to be Acquired.** We propose to form one or more new entities to purchase the assets of GWHN including all tangible and intangible assets owned or used by GWHN and its affiliates (other than the post-conversion Foundation).

We contemplate that the assets would be conveyed and assigned free and clear of all liens, claims, charges or encumbrances. Other than as set forth in Section 3 of this Letter, Prospect will not assume any liabilities except those liabilities specifically agreed to as part of definitive agreements for the transaction.

2. **Proposed Purchase Price.** Assuming that GWHN's consolidated balance sheet at closing would be free of all debt (including pension liabilities) and cash, Prospect is prepared to offer a total consideration of $100 million (based on GWHN's financial statements as presented to date) for the assets of GWHN as described above. The consideration is broken down as follows:

Consideration for Assets	$45 million
Capital Commitment	$55 million
Total	$100 million

After the closing, Prospect commits to spend at least $55 million within seven years on capital projects including routine and non-routine capital expenditures for the benefit of the facilities and operations of GWHN. The Capital Commitment shall be reduced by the amount of capital leases assumed at closing up to a maximum reduction of $3.0 million.

3. **Assumption of Pension and Other Liabilities.** Prospect shall assume GWHN's pension liability, capital lease obligations and asbestos abatement liability.

4. **Purchase Price Adjustment.** Subject to the terms and conditions of the definitive agreements, the consideration to be paid at closing shall be reduced by the amount of the pension liability, the amount of any capital leases assumed in excess of $3.0 million and all other liabilities assumed by Prospect. Furthermore, the consideration paid at close shall be increased or decreased, as the case may be, by an amount equal to the difference between the net working capital of GWHN at the time of the close and $6.8 million. By way of example, if the networking capital of GWHN is $7.8 million at the time of the closing, then the consideration paid at closing shall be increased by $1 million. However, if the networking capital of GWHN is $5.8 million at the time of the close, then the consideration paid at closing shall be decreased by $1 million.

5. **Other Facilities.** The transaction contemplated by this Letter shall not be contingent on Prospect purchasing any other hospital or healthcare facility not owned by GWHN.

6. **Employees.** We do not foresee any changes in the management of GWHN. It has been our practice and preference to rely on the existing strong management in place at the time of the transaction. In addition, Prospect will make all of its resources (both financial and human capital) available to GWHN's management team in order to execute on the strategic plan and develop a healthcare delivery system with population health management and accountable care capabilities. We anticipate hiring substantially all of the employees of GWHN who are active and in good standing at the time of the closing.

7. **Medical Staff.** Prospect would work with the local community advisory board, described below, and GWHN's medical staff members to preserve the existing staff membership and the current privileges of each physician as well as the medical staff leadership. Prospect is a physician-centric company and believes that the delivery of quality healthcare services depends on quality physicians.

We intend to develop a network of healthcare clinics and independent physician associations to support, enhance and implement the mission and vision of GWHN and to implement the CRC model. The establishment of a strong physician network necessarily requires the recruitment of additional high quality physicians to GWHN's medical staff. We intend to use our experience and physician alignment strategies in order to form lasting physician relationships.

Furthermore, we intend to support any existing initiatives and provide additional quality and safety expertise and protocols, as necessary, to achieve high satisfaction among patients, physicians, employees and volunteers. A commitment to excellence is of paramount importance to Prospect. Our desired culture is an environment which rewards teamwork, communication, accountability, learning and respect. Recent reimbursement changes and the advent of value-based purchasing programs emphasize the importance of quality and satisfaction across all constituents.

8. **Governance.** Prospect believes that the delivery of health care is local in nature and as such, Prospect depends on meaningful input from local community and physician leaders. Prospect is extremely flexible on issues relating to local governance. We propose to form a local community advisory board comprised of local community members and physicians. To that end, we welcome and encourage the continued involvement of the existing board members of GWHN with the advisory board post-closing. Generally, post-transaction, the Board of Directors for GWHN will receive input from a local advisory board. Pending further discussions with the current GWHN board, we propose the following:

(A) Board Representation. Post-transaction, Prospect will appoint a local community advisory board. A significant and pre-determined number of the members of the local community advisory board shall be members of the local community and practicing physicians. Prospect would prefer that at least some of the current members of the Board of Directors of GWHN agree to serve on such local community advisory board at the hospital. A member of the Board of Directors of the GWHN acquiring entity post transaction shall be a member of the local community advisory board. That way there is a

direct communication between the local community advisory board and the board of directors.

(B) Roles and Responsibilities of the Local Community Advisory Board. The local community advisory board shall serve in an advisory capacity to Board of Directors post transaction. The roles and responsibilities of the local community advisory board shall be as follows:

(i) Make recommendations and suggestions regarding the mission, vision and value statements with respect to GWHN post transaction;

(ii) make recommendations and suggestions with respect to medical staff credentialing, disciplinary action of staff physicians, and compliance with accreditation requirements;

(iii) provide input on policies and clinical programs;

(iv) provide input in the development and review of strategic plans;

(v) provide input on operating and capital budgets;

(vi) provide input and support physician recruitment efforts;

(vii) provide input on succession plans for executive leadership at the hospital;

(viii) promote community health initiatives, fostering community relationships and identifying service and education opportunities; and

(ix) monitor the commitment to maintain and improve quality indicators.

As stated above, since we value local input into operations, in addition to the above, we are amenable to other suggestions and/or proposals that the current GWHN Board of Directors may have regarding input and influence post business combination. We welcome GWHN's input on this matter.

9. Continuing Operations of Hospital. For a period of five years after the closing of the transaction, Prospect shall continue to provide essential services at the facilities and shall not merge, dissolve, consolidate, sell or otherwise dispose of the hospital without the consent of the GWHN or its designee, unless, in either case, to an Affiliate of Prospect; provided that this clause (i) shall not apply to (y) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or relates to a broader group of facilities or assets than the Hospital, or (z) any corporate-level transactions involving Prospect's assets, stock or securities, including mergers, recapitalizations or reorganizations.

10. Sale of Hospital within 3 years After the Close. In the event of a sale of all of the Facilities for cash, whether by merger, sale, or other transaction, at any time prior to the third

(3rd) anniversary of the Closing for a purchase price in excess of (a) the Purchase Price paid by Prospect for the assets of GWHN plus (b) the amount of any expenditures made by Prospect or its Affiliates with respect to the Facilities and their affiliated businesses in the Greater Waterbury region in such period, plus (c) any losses generated by the Facilities and its affiliated businesses in such period (such amount, the "Net Hospital Value"), then Prospect agrees to convey to Seller or its designee immediately upon closing of such transaction by wire transfer of immediately available funds in an amount equal to twenty percent (20%) of the difference between (i) the Net Hospital Value, and (ii) the cash purchase price paid to Prospect in connection with such subsequent sale transaction. Notwithstanding anything to the contrary this section shall not apply to (x) any sale required by a Governmental Entity, (y) any merger, sale or other transaction that does not relate solely or principally to the Greater Waterbury Hospital, or relates to a broader group of facilities or assets than the Facilities, or (z) any corporate-level transactions involving Prospect's stock or securities, including macro-level mergers, recapitalizations or reorganizations.

11. Charity Care. Prospect recognizes the importance of community service and charity care within the communities served by GWHN. Prospect is proud of its institutional tradition of providing charity care to uninsured and the under-insured members of its hospital communities. Subject to diligence, Prospect intends to adopt GWHN's charity care policies. Prospect will operate its charity care program in accordance with federal and state laws. Prospect will continue to provide medically necessary services to the surrounding communities served by GWHN.

12. Advance of Expenses. Prospect is aware of GWHN's desire for termination fees and/or an arrangement that includes the sharing of GWHN's costs with respect to this transaction. As GWHN is aware, Prospect has had a very limited period of time and very limited access to GWHN's data. Notwithstanding, Prospect agrees to the following:

(a) During the first thirty (30) days following the populating of the data room by GWHN critical diligence documents described in Exhibit A attached, each of Prospect and GWHN shall bear their own expenses pursuant to Section 15 below;

(b) Prospect shall, within 30 days of presentation of an invoice, reimburse GWHN for its direct out-of-pocket transaction costs in an amount up to $50,000 for each thirty (30) day period beginning upon the expiration of the thirty (30) day period described in Section 12(a) above, and ending on the date the Certificate of Need is filed with the Connecticut Department of Public Health; provided further, that (i) if expenses in any such thirty (30) day period are less than $50,000, the excess of $50,000 over such amount of expenses may be carried over to the next thirty (30) day period such that expenses subject to reimbursement in the following thirty (30) day period would be allowable up to $50,000 plus such carried over amount from the prior thirty (30) day period, and (ii) total expense reimbursement pursuant to this Section 12(b) shall not exceed $150,000;

(c) When the expense cap of $150,000 is reached in accordance with Section 12(b), Prospect and GWHN, each shall then bear their own expenses pursuant to Section 15;

(d) Should the proposed transaction close, then the amount of expenses reimbursed pursuant to Section 12(b) above shall be deducted from the purchase price paid by Prospect; and

(e) If at the end of the Exclusivity Period (as defined in Section 14), Prospect desires to move forward with a transaction on substantially the same economic terms as described above, and GWHN desires to not go forward with such a transaction, then GWHN shall repay Prospect for any funds reimbursed by Prospect pursuant to Section 12(b) above.

13. Conditions to Transaction. The Transaction Documents would include customary legal and business provisions mutually agreed upon by the parties. In addition to any other requirement set forth in this Letter of Intent, the consummation of the proposed transaction shall be subject to and contingent upon each of the following being satisfied at closing:

a. The negotiation and delivery of mutually satisfactory Transaction Documents;
b. Completion and satisfaction of the results of due diligence by Prospect, in its sole and absolute discretion;
c. The approval of the transaction by Prospect's board of directors, in its sole and absolute discretion; and
d. Receipt of any necessary governmental consents or approvals.

14. Exclusive Negotiations. GWHN and Prospect shall enter into exclusive negotiations regarding the proposed transaction. During the Exclusivity Period (as defined below), neither, GWHN nor any of their respective representatives, directly or indirectly, shall: (i) offer any of the assets described in this Letter of Intent for sale, lease or other disposition to any person or entity other than Prospect; (ii) merge, or conduct a business combination of any sort involving, GWHN or any of its affiliates with any other person or entity; (iii) transfer the membership, control, or any ownership interest in GWHN or any of its affiliates to any other person or entity; (iv) enter into a partnership or any other joint venture involving GWHN or any of its affiliates; (v) enter into any agreement with any person or entity other than Prospect with respect to any of the matters set forth in *(i)* through *(iv)* above; (vi) solicit, encourage (by way of furnishing non-public information or otherwise), negotiate, hold discussions regarding, entertain, accept, or take any other actions to facilitate, any offers regarding any of the matters or actions set forth in *(i)* through *(v)* above. The "Exclusivity Period" shall be the period beginning on the date that this Letter of Intent is signed by GWHN (the "Execution Date") and ending at 5:00 P.M. Eastern Time one hundred twenty (120) days after GWHN completes populating the data room (the "Expiration Date").

15. Expenses. Subject to paragraph 12, above, the parties acknowledge and agree that each party shall be responsible for its own expenses in connection with its individual assessment as to whether to proceed with the proposed transaction. Accordingly, each party shall pay for its own fees and expenses and those of its respective agents, representatives and advisors, including but not limited to all attorneys and accountants with respect to the negotiations of this Letter of

Intent, the negotiation of the Transaction Documents, and if the Transaction Documents are executed, the closing the transaction and any other transactions contemplated by the Transaction Documents. Notwithstanding the foregoing, in the event that Prospect and St. Mary's negotiate a transaction, GWHN shall not be responsible for any fees related to federal and state anti-trust reviews. All such costs related to an anti-trust review related to a transaction involving St. Mary's shall be the responsibility of St. Mary's or Prospect.

16. Entire Agreement; Future Modifications. Except for the Mutual Nondisclosure Agreement dated as of March 9, 2015 (the "Confidentiality Agreement"), 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. This Letter of Intent may be modified or waived only by a separate written agreement signed by the parties hereto.

17. 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 shall operate as a waiver of such right, power, or privilege, and no single or partial exercise of any such right, power, or privilege shall preclude any other or further exercise of such right, power, or privilege or the exercise of any other right, power, or privilege. A waiver shall be applicable only in the specific instance for which it is given. To the maximum extent permitted by 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 shall be applicable except in the specific instance for which it is given; and (iii) no notice to or demand on one party shall 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.

18. Severability. The invalidity or unenforceability of any provision of this Letter of Intent shall not affect the validity or enforceability of any other provisions of this Letter of Intent, which shall remain in full force and effect. If any provision of this Letter of Intent is determined to be unenforceable by reason of its extent, duration, scope or otherwise, then the parties contemplate that the court making such determination shall reduce such extent, duration, scope or other provision and enforce them in their reduced form for all purposes contemplated by this Letter of Intent.

19. Costs. In the event of any action or other proceedings between or among the parties hereto with respect to the Binding Provisions (defined below), the non-prevailing party or parties to such action or proceedings shall pay to the prevailing party or parties all costs and expenses, including reasonable attorneys' and expert witness fees, incurred in the defense or prosecution thereof by the prevailing party or parties. The prevailing party shall be determined by the judge(s) or other person hearing the matter and shall be the party who is entitled to recover its costs of suit, whether or not the matter proceeds to a final judgment or award. A party not entitled to recover its costs of suit shall not recover attorneys' fees. If a prevailing party or parties shall recover a decision, judgment or award in any action or proceedings, the costs and

expenses awarded to such party or parties may be included in and as part of such decision, judgment or award.

20. Section Headings. The headings of the sections in this Letter of Intent are provided for convenience only and shall not affect its construction or interpretation.

21. Governing Law. This Letter of Intent shall be governed by the laws of the State of New Connecticut without regard to conflicts of laws principles with Connecticut courts having exclusive jurisdiction over any matters addressed in this Letter of Intent.

22. Counterparts. This Letter of Intent may be executed in two or more counterparts, each of which shall be deemed to be an original copy of this Letter of Intent, and all of which, when taken together, shall be deemed to constitute one and the same agreement.

23. Notices. All notices, requests, demands or other communications required or permitted to be given under this Letter of Intent shall be in writing and shall be delivered to the Party to whom notice is to be given, to the notice addresses set forth below, either (i) by personal delivery (in which case such notice shall be deemed given on the date of delivery), (ii) by next business day courier service (e.g., Federal Express, UPS or other similar service) (in which case such notice shall 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, certified, return receipt requested (in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service).

If to GWHN:

Carl D. Contadini
c/o The Waterbury Hospital
64 Robbins St.
Waterbury, CT 06708

With a simultaneous copy to:

Ann H. Zucker, Esq.
Carmody Torrance Sandak & Hennessey LLP
707 Summer St
Stamford, CT 06901-1026

If to Prospect:

Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025
Attn.: Samuel S. Lee

With a simultaneous copy to counsel for Prospect:

Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025
Attn.: Ellen Shin, General Counsel

24. Due Diligence, Access to Information, Access to Facilities. Prospect has, conducted an initial review and examination of certain data and information with respect to the GWHN and its affiliates. The parties agree and acknowledge that Prospect requires further due diligence review and requires access to additional information and GWHN's facilities above and beyond that which has been provided to Prospect prior to the execution of this Letter of Intent. During the Exclusivity Period GWHN and its affiliates will provide Prospect with reasonable access to (i) information and materials related to GWHN, its affiliates and their respective related assets as requested by Prospect from time to time, and (ii) all real property, facilities and equipment that are part of the proposed transaction.

25. Confidentiality. The existence and terms of this Letter of Intent, and the matters contemplated herein, shall be subject to the terms and requirements of the Confidentiality Agreement.

26. Ordinary Course. Until the earlier of the closing of the proposed transaction or termination of this Letter of Intent, GWHN and its affiliates shall conduct business in the ordinary course of business and shall not sell or dispose of any asset other than in ordinary course.

27. Term. The term of this Letter of Intent shall commence as of the Execution Date and shall continue in effect during the Exclusivity Period unless extended by mutual agreement of the parties. Notwithstanding the foregoing, Prospect may elect to terminate this Letter at any time immediately upon written notice to GWHN and reimburse GWHN for any expenses in accordance with Section 12.

28. Binding Provisions. The obligations of GWHN and Prospect under Section 12, and Sections 14 through Section 29 (collectively, the "Binding Provisions"), shall be binding on all parties. All other provisions shall be non-binding on the parties.

29. Non-Binding With Respect to Consummation of Proposed Transaction. This Letter of Intent represents an expression of intent only with respect to the consummation of the proposed transaction. Accordingly, unless and until the Transaction Documents are executed and all other conditions to closing have been satisfied or waived, no party shall be obligated to consummate the proposed transaction. As a result, in the absence of the Transaction Documents or any other definitive agreements between the parties with respect to the proposed transaction, and subject to the Binding Provisions, none of the expiration or earlier termination of the Exclusivity Period, the failure by either Party to agree to extend the Exclusivity Period or the failure by either Party to agree to the Transaction Documents shall, in and of itself, 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 proposed transaction or the consummation thereof. No past or future action, course of conduct, or failure to act relating to

the proposed transaction, or relating to the negotiations of the terms of the Transaction Documents, will give rise to or serve as a basis for any obligation or other liability on the part of any party. The parties acknowledge and agree that this Letter of Intent is an expression made in good faith by Prospect regarding Prospect's intentions. The omission of certain terms from this Letter of Intent shall not be construed so as to diminish the importance or the materiality of such term, and the parties acknowledge that, in addition to the proposed terms contained in this Letter of Intent, additional material terms remain to be resolved. It shall remain in the sole and absolute discretion of each party whether or not to enter into any definitive agreements or transactions with the other party, or parties, and no party shall have any liability or obligation for failing to do so except as expressly provided in this Letter of Intent.

If this Letter of Intent is acceptable to GWHN, we ask that GWHN please sign and date this Letter of Intent where indicated below. Please return an originally signed and completed copy of this Letter of Intent to me. This Letter of Intent shall have no force or effect if not executed and returned to Prospect prior to 5:00 p.m. Eastern Standard Time on May 4, 2015.

We look forward to working with you.

Very truly yours,
PROSPECT MEDICAL HOLDINGS, INC.

Samuel S. Lee
Chief Executive Officer

Accepted and Agreed.

Greater Waterbury Health Network

By: Carl D Contadini

Name: CARL D CONTADINI

Title: CHAIRMAN GWHN

Dated: 5-1-2015

Exhibit A

1. Audited Financial statements for the past two years
2. Most recent unaudited interim financial statement and the statements for the corresponding period of the previous fiscal year
3. Identification of all one-time revenue and expense items for the past two years and YTD.
4. Last fiscal year and YTD detailed financial statements
5. Current year budget, including Capital expenditure budget
6. Any reports, studies and projections prepared internally or externally on the GWHN's financial condition and planned operations
7. Most recent marketing and/or strategic plans
8. Contracts with Unions and other labor agreements
9. Summary of annual occupancy, CMI, length of stay and other census trending reports detailed by payer mix and by program for 2013, 2014 and YTD 2015
10. Board of Director statistics and reports prepared by GWHN management to describe the financial condition of GWHN
11. Actuarial reports related to all pension plans
12. Identified strategic growth and cost initiatives
13. Copies of corporate integrity agreements, or any similarly mandated corporate compliance programs imposed by any state or federal regulatory authority along with all settlement agreements currently in effect, in process of negotiations, or that were in effect in past 3 years
14. Summary of any regulatory investigations currently active or conducted within the last three years involving GWHN by any federal or state regulatory authorities including copies of findings and corrective action plans
15. Summary of E.H.R. meaningful use implementation
16. Description of ICD-10 implementation / readiness
17. Most recent marginal cost or marginal contribution analyses on any and all programs
18. Medicare Cost reports for the past 2 years
19. All third party valuations on GWHN's properties.
20. Admissions by physician for past 12 months
21. Admissions / Discharges by financial class for past 12 months
22. ER conversion rate by financial class
23. Outlier and transfer DRG reports
24. Medicare and Medicaid admissions by DRG and length of stay
25. Admissions by source
26. Labor productivity reports for the past 12 months
27. Top 20 vendors for purchase services (other than supplies)
28. Top 20 supply item purchases and per unit cost

AMENDMENT NO. 1 TO LETTER OF INTENT

This AMENDMENT NO. 1 TO LETTER OF INTENT (this "Amendment") is made as of the 28th day of August, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("Seller").

WHEREAS, PMH and Seller are parties to that certain Letter of Intent dated April 30, 2015 (the "LOI"); and

WHEREAS, the parties have agreed to extend the "exclusivity provision" of the LOI.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Paragraph 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on September 8, 2015.

2. Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the LOI.

3. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By:_____
Name:
Title:

GREATER WATERBURY HEALTH NETWORK, INC.

By:_____
Name: DARLENE STRONSTAD
Title: Pres/CEO

AMENDMENT NO. 2 TO LETTER OF INTENT

This AMENDMENT NO. 2 TO LETTER OF INTENT (this "Amendment") is made as of the 10 day of September, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("Seller").

WHEREAS, PMH and Seller are parties to that certain Letter of Intent dated April 30, 2015 (as amended on August 28, 2015, the "LOI"); and

WHEREAS, the parties have agreed to extend the "exclusivity provision" of the LOI.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Paragraph 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on September 15, 2015.

2. Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the LOI.

3. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By: _____
Name: Sam Lee
Title: CEO

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____
Name: DARLENE STRUMSTAD
Title: Pres/CEO

AMENDMENT NO. 3 TO LETTER OF INTENT

This AMENDMENT NO. 3 TO LETTER OF INTENT (this "Amendment") is made as of the 14 day of September, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("Seller").

WHEREAS, PMH and Seller are parties to that certain Letter of Intent dated April 30, 2015 (as previously amended on August 28, 2015, and on September 10, 2015, the "LOI"); and

WHEREAS, the parties have agreed to extend the "exclusivity provision" of the LOI.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Paragraph 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on October 5, 2015.

2. Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the LOI.

3. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By: _____
Name: SAMUEL S. LEE
Title: CHIEF EXECUTIVE OFFICER

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____
Name: DARLENE STRONSTAD
Title: Pres/CEO

EXECUTION VERSION

AMENDMENT NO. 4 TO LETTER OF INTENT

This AMENDMENT NO. 4 TO LETTER OF INTENT (this "Amendment") is made as of the 27 day of October, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("GWHN").

WHEREAS, PMH and GWHN are parties to that certain Letter of Intent dated April 30, 2015, as amended by that certain Amendment No. 1 to Letter of Intent dated August 28, 2015, by that certain Amendment No. 2 to Letter of Intent dated September 10, 2015, and by that certain Amendment No. 3 to Letter of Intent dated September 14, 2015 (as so amended, the "LOI"); and

WHEREAS, the parties have agreed to reaffirm their respective obligations thereunder and to make certain amendments thereto to include mutually agreed upon binding covenants of the parties that will be effective until the Expiration Date.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Section 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on the earlier of (x) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the Letter of Intent, and (y) ninety (90) days following the receipt by the parties of the certificate of need approval for The Waterbury Hospital ("Hospital") by the Office of Healthcare Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Office of the Attorney General of the State of Connecticut (the "Expiration Date"); provided, however, that, notwithstanding the receipt of such approvals, Prospect shall have the right, if Prospect is diligently contesting in good faith any of the terms or conditions of such approvals, including, without limitation, pursuing any changes in respect of the conditions imposed on the operation of the Hospital or the related businesses or any other modifications set forth in such approval, (a) exercisable upon prior written notice to GWHN, to extend the Expiration Date by up to an additional thirty (30) days; and (b) with the written consent of GWHN, to extend the Expiration Date by such longer period as the parties may agree upon.

2. Section 28 of the LOI shall be deleted in its entirety and replaced with the following:

"28. **Binding Provisions**. The obligations of GWHN and Prospect under Section 12, and Section 14 through Section 30 (collectively, the "Binding Provisions"), shall be binding on all parties. All other provisions shall be non-binding on the parties."

3. The first sentence of Section 29 of the LOI shall be deleted in its entirety and replaced with the following:

"29. **Non-Binding With Respect to Consummation of Proposed Transaction.** Except as otherwise set forth in this Letter of Intent, and subject to the Binding Provisions, this

Letter of Intent represents an expression of intent only with respect to the consummation of the proposed transaction.

The remainder of Section 29 shall remain in full force and effect.

4. A new Section 30 of the LOI is hereby added immediately following Section 29 of the LOI, as follows:

30. **Covenants.** Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in Annex A hereto.

(a) Access to and Provision of Additional Information.

(i) GWHN shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Prospect full and complete access to and the right to inspect the plants, properties, books, and records of the Hospital Businesses, and will furnish Prospect with such additional financial and operating data and other information as to the business and properties of GWHN pertaining to the Hospital Businesses as Prospect may from time to time reasonably request without regard to where such information may be located. Prospect's right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Hospital Businesses and the delivery of patient care. Prospect agrees that no inspections shall take place and no employees or other personnel of the Hospital Businesses shall be contacted by Prospect without Prospect's first providing reasonable notice to GWHN and coordinating such inspection or contact with GWHN.

(ii) Within two (2) business days after they are created (but in any event no later than fifteen (15) days following the end of each calendar month prior to the Expiration Date), GWHN shall deliver or cause to be delivered to Prospect true and complete copies of the management prepared unaudited balance sheets and the related unaudited statements of income of, or relating to, GWHN and its Wholly Owned Subsidiaries in respect of the Hospital Businesses for each month then ended, which presentation shall be true, correct, and complete in all material respects, shall have been prepared from and in accordance with the books and records of GWHN and its Wholly Owned Subsidiaries in respect of the Hospital Businesses, and shall fairly present the financial position and results of operations of GWHN and its Wholly Owned Subsidiaries in respect of the Hospital Businesses as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such financial statements need not include required footnote disclosures. To the extent permitted by law, GWHN shall notify Prospect in writing and shall keep Prospect informed of any unexpected emergency or other materially adverse unanticipated change in the business of any of the Hospital Businesses and of any governmental complaints,

investigations, or adjudicatory proceedings (or governmental communications indicating that the same may be contemplated) or of any other such matter.

(iii) Until the Expiration Date, to the extent permitted by law, GWHN shall confer regularly with Prospect, as reasonably requested by Prospect, and answer Prospect's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Letter of Intent. GWHN shall notify Prospect of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, grievances, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Prospect reasonably informed of the status of such matters.

(iv) With respect to any individually identifiable health information disclosed by GWHN to Prospect pursuant to this Section, Prospect and GWHN shall comply with HIPAA and with any other Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

(v) For the avoidance of doubt, Prospect shall not, and nothing contained in this Section shall give Prospect, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the closing of the transactions contemplated by this Letter of Intent.

(b) Governmental Approvals.

(i) GWHN's Obligations.

(1) GWHN shall (A) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow GWHN to perform its obligations under this Letter of Intent (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein); and (B) assist and cooperate with Prospect and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Prospect deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that

Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein).

(2) GWHN shall, if and to the extent required by Legal Requirements, file all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Letter of Intent. GWHN agrees to furnish to Prospect such information concerning GWHN as Prospect needs to perform its obligations under Section 30(b)(ii)(2) of this Letter of Intent.

(ii) Prospect's Obligations.

(1) Prospect shall (A) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Prospect to perform its obligations under this Letter of Intent (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein), and (B) assist and cooperate with GWHN and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that GWHN deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein). Prospect shall pay all of the costs of any fees due in respect of filings made to the Attorney General and Commissioner of Public Health of the State of Connecticut, including, without limitation, fees required to be paid by Prospect pursuant to CT Gen Stat § 19a-486c(c) and CT Gen Stat § 19a-486d(a) shall remain the obligation of Prospect.

(2) Prospect shall, if and to the extent required by Legal Requirements, file or cause to be filed all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the

transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Letter of Intent. Prospect agrees to furnish to GWHN such information concerning Prospect as GWHN needs to perform its obligations under Section 30(b)(i)(2) of this Letter of Intent. Prospect shall pay the costs of any fees due in respect of filings required by the HSR Act.

(c) Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Letter of Intent, whenever this Letter of Intent requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

(d) CON Disclaimer. This Letter of Intent shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate Governmental Authority shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

(e) Fees and Expenses.

(i) Except as otherwise expressly set forth in this Letter of Intent, whether or not the transactions contemplated by this Letter of Intent are consummated, (1) Prospect or its Affiliates shall bear and pay all expenses incurred by or on behalf of Prospect in connection with Prospect's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Letter of Intent and Prospect's performance of its obligations pursuant to this Letter of Intent, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (2) GWHN shall bear and pay all expenses incurred by or on behalf of GWHN, or its Affiliates or Wholly Owned Subsidiaries, in connection with the preparation and negotiation of this Letter of Intent and GWHN's performance of its obligations pursuant to this Letter of Intent, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(ii) GWHN shall pay all costs reasonably necessary for GWHN to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by GWHN in obtaining any third party consents or approvals necessary to assign to Prospect any Assumed Contracts (it being understood that GWHN shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than 1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(iii) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Letter of Intent and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

5. A new Section 31 of the LOI is hereby added immediately following Section 30 of the LOI:

"31. **Asset Purchase Agreement**. The parties agree to use the Asset Purchase Agreement attached hereto as Annex B, in substantially similar form, subject to any revisions that may be necessary or appropriate, in Prospect's reasonable discretion, based on its due diligence."

6. A new Section 32 of the LOI is hereby added immediately following Section 31 of the LOI, as follows:

"32. **Not a Sale of a Hospital**. Notwithstanding anything to the contrary set forth herein, this Letter of Intent shall not constitute, or be deemed to constitute, an agreement to transfer a material amount of a nonprofit hospital's assets or operations or a change in control of a hospital's operations, it being expressly understood that no such agreement shall be entered into without first having received approval of such agreement by the Commissioner of Public Health of the State of Connecticut and the Attorney General."

7. Where the context requires, references to "*this Letter of Intent*" or "*this Letter*" mean the LOI, as amended by this Amendment, and all Annexes and Schedules attached to or referenced in this LOI;

8. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[Signature Page Follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

GREATER WATERBURY HEALTH NETWORK, INC.

By:_____
Name: Darlene Stromstad
Title: Pres/CEO

[*Signature page to Amendment No. 4 to Letter of Intent*]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

GREATER WATERBURY HEALTH NETWORK, INC.

By:_____
Name:
Title:

[Signature page to Amendment No. 4 to Letter of Intent]

Annex A

Certain Definitions

(1) **Affiliate** means as to the Person in question, any Person that directly or indirectly controls, is controlled by, or is under common control with the Person 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 a Person, whether through ownership of voting securities, by contract, or otherwise;

(2) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by GWHN wherever located and whether or not reflected in the financial statements of GWHN and its Wholly Owned Subsidiaries.

(3) **Assumed Contracts** means the Contracts, the leases relating to the Leased Real Property, the leases relating to the leased personal property, and all Immaterial Contracts not specifically designated by Prospect as an Excluded Contract at or prior to the closing of the transactions contemplated by this Letter of Intent;

(4) **Attorney General** means the Office of the Attorney General of the State of Connecticut;

(5) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which GWHN or any Wholly Owned Subsidiary of GWHN is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retirement, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(6) **Converted Ventures** means the Non-Profit JVs that have been converted to new for-profit entities;

(7) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, easements, restrictions, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(8) **Excluded Contracts** means the commitments, contracts, leases, and agreements other than the Assumed Contracts;

(9) **FTC** means the United States Federal Trade Commission;

(10) **GAAP** means United States generally accepted accounting principles;

(11) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(12) **HIPAA** means the federal Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, as amended;

(13) **Hospital** means The Waterbury Hospital (a tax-exempt entity), an acute care teaching hospital having 357 licensed beds;

(14) **Hospital Businesses** means the entities and businesses operated by GWHN and its Wholly Owned Subsidiaries, including the Hospital; *provided*, that, for the avoidance of doubt, the parties hereby agree and acknowledge that the term "Hospital Businesses" does not include the Joint Ventures or Converted Ventures or any of their health care facilities, assets or businesses;

(15) **HSR Act** means the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(16) **Immaterial Contract** means any Contract to which GWHN or any of its Wholly Owned Subsidiaries is a party that requires either the payment by GWHN or its Wholly Owned Subsidiaries of $25,000 or less or the provision of goods or the performance of services by GWHN or any of its Wholly Owned Subsidiaries having a value of $25,000 or less, in either case during the period from the date of this Letter of Intent until (i) if the Contract is terminable at any time by GWHN or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if GWHN or the respective Wholly Owned Subsidiary was to give notice of termination on the date of this Letter of Intent, or (ii) if the Contract is not terminable at any time by GWHN or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract that may otherwise be deemed material by the parties;

(17) **Joint Ventures** means Access Rehab Centers, LLC, Greater Waterbury Imaging Center, LP, Imaging Partners, LLC, Heart Center of Greater Waterbury, Inc., The Harold Leever Regional Cancer Center, Inc., Waterbury Gastroenterology Co-Management Company, LLC, and Valley Imaging Partners, LLC;

(18) **Justice Department** means the United States Department of Justice;

(19) **Leased Real Property** means the real property, together with all buildings, improvements and fixtures thereon, that is leased by GWHN or any Wholly Owned Subsidiaries of GWHN;

(20) **Legal Requirements** means, with respect to any Person, all federal, state and local statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, policies, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(21) **Non-Profit JVs** means Heart Center of Greater Waterbury, Inc. and The Harold Leever Regional Cancer Center, Inc.;

(22) **Permitted Encumbrances** means those Encumbrances identified by the parties prior to the closing of the transactions contemplated by this Letter of Intent as being Permitted Encumbrances;

(23) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(24) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(25) **Wholly Owned Subsidiary** means, with respect to any Person, (i) any corporation 100% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Wholly Owned Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Wholly Owned Subsidiaries of such Person has a 100% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Wholly Owned Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (a) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (b) whose sole member is such Person; *provided*, *however*, that with respect to GWHN, includes, without limitation, the Hospital, Greater Waterbury Health Services, Inc., VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc., Children's Center of Greater Waterbury Health Network, Inc., Alliance Medical Group, Inc., and Cardiology Associates of Greater Waterbury, LLC;

(26) Certain References. As used in this Letter of Intent:

ii. references to "*this Letter of Intent*" or "*this Letter*" mean the LOI, as amended by that certain Amendment No. 1 to Letter of Intent dated August 28, 2015, by that certain Amendment No. 2 to Letter of Intent dated September 10, 2015, by that certain Amendment No. 3 to Letter of Intent dated September 14, 2015, and as further amended by this Amendment, and all Annexes and Schedules attached to or referenced in this LOI;

iii. references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Letter of Intent, unless the context states or implies otherwise;

iv. references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

v. references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

vi. references to "*partnerships*" include general and limited partnerships;

vii. references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

viii. references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

ix. references to time are references to Eastern Time;

x. references to "*GWHN's Knowledge,*" "*Knowledge of GWHN*," or words of similar intent or effect mean and refer to (x) all matters with respect to which GWHN or any of its Wholly Owned Subsidiaries has received written notice, and (y) the knowledge of each of the Persons whose names or titles are set forth on Schedule A, after due inquiry by GWHN (or Wholly Owned Subsidiary, as applicable) of such Persons;

xi. the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

xii. the use of captions and headings in connection with this Letter of Intent is solely for convenience and has no legal effect in construing this Letter of Intent.

Annex B

[Attach Asset Purchase Agreement]

INTENTIONALLY OMITTED

Schedule A

Persons with □GWHN□s □nowledge□

[●]	President and Chief Executive Officer
[●]	Senior Vice President and Chief Operating Officer
[●]	Vice President□Chief Financial Officer
[●]	Vice President Medical Affairs□Chief Medical Officer
[●]	Vice President Patient Care□Chief Nursing Officer
[●]	Vice President Information Services□Chief Information Officer
[●]	Chief Medical Information Officer
[●]	Vice President Human Resources
[●]	Director □Compliance and HIPAA
[●]	Assistant Director Finance □Corporate Accounting
[●]	Corporate Compliance Officer
[●]	Administrative Director Facility Operations

EXHIBIT Q3-2

DRAFT ASSET PURCHASE AGREEMENT

ASSET PURCHASE AGREEMENT

by and between

GREATER WATERBURY HEALTH NETWORK, INC.

SELLER

and

[●]

BUYER

Dated as of [●], 2015

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ASSET PURCHASE AGREEMENT

This **ASSET PURCHASE AGREEMENT** (this "**Agreement**"), dated _____, 2015, is by and between Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("**Seller**"), on its behalf and on behalf of its Wholly Owned Subsidiaries, and [●], a Connecticut corporation ("**Buyer**"), with Prospect Medical Holdings, Inc. ("**PMH**"), a Delaware corporation and the indirect owner of Buyer, joining for the limited purposes described herein.

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of the Seller and its Wholly Owned Subsidiaries, including The Waterbury Hospital (a tax-exempt entity), an acute care teaching hospital having 357 licensed beds (the "**Hospital**"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc., Alliance Medical Group, Inc., and Cardiology Associates of Greater Waterbury, LLC (the entities and businesses operated by Seller and its Wholly Owned Subsidiaries, including the Hospital, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Access Rehab Centers, LLC, Greater Waterbury Imaging Center, LP, Imaging Partners, LLC, Heart Center of Greater Waterbury, Inc., The Harold Leever Regional Cancer Center, Inc., Waterbury Gastroenterology' Co-Management Company, LLC, and Valley Imaging Partners, LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**"); *provided*, that, for the avoidance of doubt, the parties hereby agree and acknowledge that the term "Hospital Businesses" does not include the Joint Ventures or Converted Ventures (as such term is hereinafter defined) or any of their health care facilities, assets or businesses;

WHEREAS, Buyer desires to purchase substantially all of the assets, real, personal and mixed, tangible and intangible, of Seller and the Wholly Owned Subsidiaries, including the Hospital Businesses and the equity interests in the Joint Ventures and Converted Ventures; and

WHEREAS, Seller has concluded that the transactions contemplated by this Agreement are in its best interests and consistent with its charitable mission of the promotion of health care in the communities served by the Hospital Businesses.

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 are forever acknowledged, the parties, intending to be legally bound, agree as follows:

AGREEMENT:

1. DEFINITIONS AND REFERENCES

1.01. Definitions. For purposes of this Agreement, the following definitions apply:

(1) **20-Day Period** is defined in Section 2.05(f);

(2) **Accessibility Laws** is defined in Section 3.11(b)(iv);

(3) **Accountants' Determination** is defined in Section 2.05(f);

(4) **Accounts Receivable** means all accounts, notes, interest, and other receivables of the Hospital Businesses, including, without limitation, those certain accounts, notes, or other receivables listed on Schedule 1.01(4), and all claims, rights, interests, and proceeds related thereto, including all accounts and other receivables, disproportionate share payments, and all rights to receive funds relating to upper payment limits, arising from the rendering of services to inpatients and outpatients at the Hospital Businesses, billed and unbilled, recorded and unrecorded, accrued and unaccrued, for services provided by Seller or the Wholly Owned Subsidiary, as applicable, while owner of the Assets, whether payable by private pay patients, private insurance, third party payors, Government Payment Programs, or by any other source, and accounts that have been written off, but excluding all Cost Report settlement amounts;

(5) **Accumulated Benefit Obligation**[1] means the accumulated benefit obligation of Seller's **[or its Wholly Owned Subsidiary's]**[2] defined benefit pension plan, the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan, determined for purposes of Seller's audited financial statements as of [•, 20__] using GAAP (i) reflecting the assumptions used for purposes of **[Note •]** of such financial statements (as updated for the RP-2014 mortality tables prepared by the Society of Actuaries) and (ii) assuming continuation of the Seller's **[or its Wholly Owned Subsidiary's]** post-retiree health benefit plan and no change in its provisions after [•, 20__] (other than the freeze of such plan to new participation) **[TO BE UPDATED BASED ON DILIGENCE]**;

(6) **AEA** is defined in Section 3.12;

(7) **Affiliate** means as to the Person in question, any Person that directly or indirectly controls, is controlled by, or is under common control with the Person 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 a Person, whether through ownership of voting securities, by contract, or otherwise;

(8) **Agreement** is defined in the preamble;

(9) **Arbitrating Accountants** is defined in Section 2.05(f);

(10) **Asbestos Abatement Liability** means the amount reflected in Seller's audited financial statements;

(11) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets owned by a

[1] Subject to due diligence
[2] Subject to due diligence

Wholly Owned Subsidiary of Seller and the JV Interests, but (ii) excluding the Excluded Assets;

(12) **Assignment and Assumption Agreement** is defined in Section 9.02(c);

(13) **Assumed Contracts** is defined in Section 2.01(f);

(14) **Assumed Liabilities** is defined in Section 2.03;

(15) **Attorney General** means the Office of the Attorney General of the State of Connecticut;

(16) **Audited Financial Statements** means the audited consolidated balance sheets of Seller and its Wholly Owned Subsidiaries for the three most recently ended fiscal years, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and the report thereon of Marcum, LLP, independent certified public accountants;

(17) **Balance Sheet Date** is defined in Section 3.06(a);

(18) **Bill of Sale** is defined in Section 9.01(b);

(19) **Buyer** is defined in the preamble;

(20) **Buyer Deductible** is defined in Section 10.04;

(21) **Buyer's Indemnified Persons** means Buyer and its respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(22) **Capital Amount** means Fifty-One Million Five Hundred Thousand Dollars ($51,500,000) less the amount of Capital Lease Obligations assumed by Buyer at Closing in excess of Six Million Five Hundred Thousand Dollars ($6,500,000);

(23) **Capital Lease Obligations** means [_____];

(24) **Cash Balance Plan** is defined in Section 8.11;

(25) **CERCLA** is defined in Section 3.12;

(26) **Claim Notice** means written notification of a Third Party Claim by an Indemnitee to an Indemnifying Party under Article 9, including a Third Party Claim set forth in a "Revenue Agent's Report," "Statutory Notice of Deficiency," "Notice of Proposed Assessment," or any other official written notice from a Taxing authority that Taxes are due or that a Tax audit will be conducted;

(27) **Closing** is defined in Section 9.01(a);

(28) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Wholly Owned Subsidiaries as of the close of business on the Closing Date, which, for the avoidance of doubt, shall include Unfunded Pension Liabilities as a line item thereon, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

(29) **Closing Date** means the date upon which the Closing occurs;

(30) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing;

(31) **CMS** means The Centers for Medicare and Medicaid Services;

(32) **COBRA** means the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;

(33) **Code** means the Internal Revenue Code of 1986, as amended;

(34) **Commitment Amount** is defined in Section 6.9;

(35) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which Seller or any Wholly Owned Subsidiary of Seller is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retirement, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(36) **Converted Venture** is defined in Section 5.19;

(37) **Cost Reports** is defined in Section 6.06;

(38) **CTDEEP** is defined in Section 5.06;

(39) **DOL** means the United States Department of Labor;

(40) **DSH** means a Disproportionate Share Hospital that serves a significantly disproportionate number of low-income patients and receives payments from CMS to cover the costs of providing care to uninsured patients;

(41) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with GAAP consistently applied;

(42) **ECAF** is defined in Section 5.06;

(43) **EFT Account** is defined in Section 2.01(o);

(44) **Employee Benefit Plan** is defined in Section 3.21;

(45) **Employee Lists** is defined in Section 5.03(b);

(46) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, easements, restrictions, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(47) **Environmental Laws** is defined in Section 3.12;

(48) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended;

(49) **ERISA Affiliate** is defined in Section 3.21;

(50) **Essential Service** is defined in Exhibit C;

(51) **Establishment Real Properties** is defined in Section 5.06;

(52) **Excluded Assets** is defined in Section 2.02;

(53) **Excluded Contracts** is defined in Section 2.02(p);

(54) **Excluded Liabilities** is defined in Section 2.04;

(55) **Final Closing Statement** is defined in Section 2.05(e);

(56) **Final Determination Date** means the earliest to occur of (i) the twenty-first (21st) business day following the receipt by Seller of the Final Closing Statement and Closing Balance Sheets if Seller shall have failed to deliver the Objection Notice to Buyer within the 20-Day Period, (ii) the date on which Seller gives Buyer written notice to the effect that Seller has no objection to Buyer's determination of the amount of the actual Net Working Capital and actual Unfunded Pension Liabilities, (iii) the date on which Buyer and Seller execute and deliver a Settlement Agreement, (iv) the date as of which Buyer and Seller shall have received the Accountants' Determination, and (v) Buyer's failure to deliver the information set forth in Section 2.05(e) within the ninety (90) day period described therein.

(57) **Financial Statements** is defined in Section 3.06;

(58) **FTC** means the United States Federal Trade Commission;

(59) **GAAP** means United States generally accepted accounting principles;

(60) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(61) **Government Payment Programs** means federal and state Medicare, Medicaid, CHAMPUS and TRICARE programs, the Connecticut HUSKY Health program, and similar or successor programs with or for the benefit of Governmental Authorities;

(62) **Hazardous Substances** means and includes polychlorinated biphenyls, urea formaldehyde, asbestos, low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, and any substances, materials, constituents, chemicals, pollutants, contaminants, wastes (including medical waste), toxic substances, petroleum and petroleum products, or other elements or products that are included under or regulated by any Environmental Law, including, without limitation, CERCLA, RCRA and AEA;

(63) **Hill-Burton Act** means the federal Public Health Service Act, 42 U.S.C. §291, *et seq.*, as amended;

(64) **HIPAA** means the federal Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, as amended;

(65) **Hospital** is defined in the recitals;

(66) **Hospital Businesses** is defined in the recitals;

(67) **HSR Act** means the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(68) **Immaterial Contract** means any Contract to which Seller or any of its Wholly Owned Subsidiaries is a party that requires either the payment by Seller or its Wholly Owned Subsidiaries of $25,000 or less or the provision of goods or the performance of services by Seller or any of its Wholly Owned Subsidiaries having a value of $25,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller or the respective Wholly Owned Subsidiary was to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Section 3.17;

(69) **Indemnifying Party** means any Person obligated to indemnify another Person under Article 10;

(70) **Indemnitee** means any Person entitled to indemnification under Article 9;

(71) **Indemnification Holdback Amount** means an amount equal to Four Million Five Hundred Thousand Dollars ($4,500,000) withheld by Buyer at the Closing and held by Buyer pursuant to the terms of this Agreement for (i) any shortfall amounts due to Buyer pursuant to Section 2.05(h), and (b) any Losses reimbursed to Buyer's Indemnified Persons pursuant to Section 10.01 and Section 10.09;

(72) **Indemnification Holdback Survival Date** is defined in Section 10.09(b);

(73) **Indemnity Notice** means written notification of a claim for indemnity under Article 10, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to Section 10.05(b);

(74) **Information Systems** means the software (including object and source codes as applicable), hardware, application programs and similar systems owned, licensed or leased by Seller or its Wholly Owned Subsidiary and used in the ownership or operation of any of the Hospital Businesses, whether or not on a system-wide basis;

(75) **Intellectual Properties** means (i) all inventions (whether or not patentable or reduced to practice), all improvements thereto, and all patents, patent applications, and patent disclosures, together with all reissuances, continuations, continuations-in-part, revisions, extensions, and reexaminations thereof, (ii) all trademarks, service marks, trade dress, logos, trade names, corporate names, domain names, and all websites (together with the content therein), including all goodwill associated therewith, and all applications, registrations, and renewals in connection therewith, (iii) all copyrightable works, all copyrights, and all applications, registrations, and renewals in connection therewith, and (iv) all trade secrets and confidential business information (including ideas, research and development, know-how, formulas, compositions, manufacturing and production processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals) that are owned, licensed or leased by Seller or its Wholly Owned Subsidiaries and used in the ownership or operation of the Hospital Businesses, together with all rights to sue or make any claims for any past, present, or future infringement, misappropriation or unauthorized use of any of the foregoing rights, and the right to all income, royalties, damages and other payments that are now or may hereafter become due or payable with respect to any of the foregoing rights, including damages for past, present or future infringement, misappropriation or unauthorized use thereof;

(76) **Interim Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Wholly Owned Subsidiaries as of the most recent month end available before the Closing;

(77) **IRS** means the United States Internal Revenue Service;

(78) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments

in any other Person, or membership in a not-for-profit business organization, and proceeds from the sale thereof;

(79) **Joint Commission** is defined in Section 3.16;

(80) **Joint Ventures** is defined in the recitals;

(81) **JV Interests** is defined in Section 2.01(q);

(82) **Justice Department** means the United States Department of Justice;

(83) **Leased Personal Property** is defined in Section 2.01(c)(ii);

(84) **Leased Real Property** means the real property, together with all buildings, improvements and fixtures thereon, that is leased by Seller or any Wholly Owned Subsidiaries of Seller;

(85) **Legal Requirements** means, with respect to any Person, all federal, state and local statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, policies, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(86) **Loan Agreement** is defined in Section 5.15;

(87) **Local Board** is defined in Section 6.12;

(88) **Losses** means any and all damages, costs, losses (including any diminution in value), liabilities, expenses or obligations (including Taxes, interest, penalties, court costs, costs of preparation and investigation, and attorneys', accountants' and other professional advisors' fees and expenses);

(89) **Material Adverse Effect** means any event, change, or occurrence that, individually or together with any other event, change, or occurrence, would reasonably be expected to have a material adverse effect on the Assets (whether or not covered by insurance) or on the business, operations, results of operations, prospects, or condition (financial or otherwise) of the Hospital Businesses; *provided, however*, that the definition of "Material Adverse Effect" shall be used solely for interpreting Section 8.04 and not for interpreting the phrase "material adverse effect" or "material adverse change" as such phrases may be used in any other context elsewhere in this Agreement; and further provided, that the following will be presumed ***not to constitute a Material Adverse Effect***: (a) general economic or industry conditions generally applicable to hospitals or healthcare facilities within the United States of the State of Connecticut so long as such conditions do not disproportionately affect Seller and the Hospital Businesses; (b) changes or proposed changes to any state or federal law, reimbursement rates or policies of Governmental Authorities that are generally applicable to hospitals or to health care facilities within the United States so long as such changes do not disproportionately affect Seller and the Hospital Businesses; (c) requirements, reimbursement rates, policies,

or procedures of third party payors or accreditation commissions or organization that are generally applicable to hospitals or health care facilities within the United States; (d) changes in GAAP; (e) actions specifically required of the parties pursuant to this Agreement; and (f) the "Trailing EBITDA" shall be not less than 80% of the normalized Trailing EBITDA of the same period for the prior year; *provided, however*, that if the "Trailing EBITDA" is less than 80% of the normalized Trailing EBITDA of the same period for the prior year, then such occurrence shall constitute a Material Adverse Effect;

(90) **Material Tangible Assets** means any equipment or other material items of tangible property and assets with an original cost in excess of $250,000;

(91) **Multiemployer Plan** is defined in Section 3.21;

(92) **Net Hospital Value** is defined in Section 6.08;

(93) **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Seller and its Wholly Owned Subsidiaries acquired by Buyer, including inventory and supplies, drugs, food, Accounts Receivable, other receivables, advance payments, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time), and Net Working Capital shall be calculated in accordance with the methodology set forth on Annex A attached hereto;

(94) **Non-Profit JVs** means Heart Center of Greater Waterbury, Inc. and The Harold Leever Regional Cancer Center, Inc.;

(95) **Notice Period** is defined in Section 10.05(a)(i);

(96) **Objection Notice** is defined in Section 2.05(f);

(97) **Owned Real Property** means real property that is owned (legally or beneficially) by Seller or any Wholly Owned Subsidiary, together with all buildings, improvements and fixtures thereon owned by Seller or any Wholly Owned Subsidiary of Seller, all construction in progress, and all appurtenances, rights, privileges and easements thereto;

(98) **PBGC** means the Pension Benefit Guaranty Corporation;

(99) **Permit** means each license, provider number, permit, right, franchise, concession, certificate, authorization, consent, waiver, certificate of waiver, certificate of need, certificate of exemption, accreditation and registration, or other approval of a Governmental Authority owned or held by Seller or its Wholly Owned Subsidiaries relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(100) **Permitted Encumbrances** means those Encumbrances described on Schedule 3.11(a) as being Permitted Encumbrances;

(101) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(102) **Physician Recruitment Expenditures** means the costs related to the development and implementation of physician engagement strategies, including the costs related to sourcing and screening candidates, entering into and executing the terms of an agreement(s) to relocate a physician, including costs incurred in acquiring such physicians practice or assets, and any other similar expenditures relating to physician recruitment;

(103) **PMH** is defined in the preamble;

(104) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(105) **Purchase Price** is defined in Section 2.05;

(106) **Purchase Price Adjustment** is defined in Section 2.05(g);

(107) **RCRA** is defined in Section 3.12;

(108) **Real Property** means the Owned Real Property and the Leased Real Property;

(109) **Restricted Area** is defined in Section 6.03;

(110) **Revenue Procedure** is defined in Section 5.03(b);

(111) **Schedules** means the schedules referred to in this Agreement and attached hereto at the time that this Agreement is executed by each original party hereto;

(112) **Second 20-Day Period** is defined in Section 2.05(f);

(113) **Seller** is defined in the preamble;

(114) **Seller Deductible** is defined in Section 10.02;

(115) **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Affiliates, and, for all of them, their respective members, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(116) **Settlement Agreement** is defined in Section 2.05(f);

(117) **Special Employee Liabilities** means (i) all paid time off accruals (including vacation, holiday, and sick time benefits) of the Seller's or any Wholly Owned Subsidiary's employees, and (ii) all payments accrued as of the Closing under the Seller's or any Wholly Owned Subsidiary's long term retention payment program, culminating in **[2017]**, but in each case only to the extent there is a recorded financial obligation for Seller or its Wholly Owned Subsidiary associated with such liabilities and such recorded financial obligation is not included in the calculation of Net Working Capital;

(118) **State Health Agency** is defined in Section 3.15;

(119) **Surveys** is defined in Section 5.18;

(120) **Target Net Working Capital** means $6,800,000;

(121) **Tax** means any federal, state, local, or foreign income, unrelated business income, gross income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under Section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, employment, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, property, production, ad valorem, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, custom, duty, impost, levy or fee of any kind whatsoever, or other like assessment or charge, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(122) **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code Section 501(c)(3) organization, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(123) **Termination Fee** is defined in Section 9.04(d);

(124) **Third Party Claim** is defined in Section 10.05(a)(i);

(125) **Title Commitment** is defined in Section 5.17;

(126) **Title Company** is defined in Section 5.17;

(127) **Title Policy** is defined in Section 5.17;

(128) **Trailing EBITDA** means the normalized EBITDA of the Seller and its Wholly Owned Subsidiaries on a consolidated basis for the trailing 12-month period through the date of the most recent unaudited statements of income and cash flows of the Seller and its Wholly Owned Subsidiaries provided to Buyer pursuant to Section 5.04(b);

(129) **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*, as amended;

(130) **Transfer Act Activities** is defined in Section 5.06;

(131) **Transitional Services Agreement** means the agreement between Buyer and Seller whereby Buyer or its Affiliate will lease to Seller, at cost, employees of Seller or its Wholly Owned Subsidiaries of the Hospital Businesses who are hired by Buyer as of the Closing Date, for the orderly wind down of the benefits and administration of Seller's other post-Closing obligations (*e.g.*, finalizing Cost Reports), in substantially the form of Exhibit A attached hereto;

(132) **Unaudited Financial Statements** means the unaudited consolidated balance sheets of Seller and its Wholly Owned Subsidiaries as of [●], 2015, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the [●]-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(b);

(133) **Unfunded Pension Liabilities**[3] means the unfunded pension liabilities of Seller's or its Wholly Owned Subsidiary's defined benefit pension plan, the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan, calculated as the Accumulated Benefit Obligation reduced by the fair market value of the assets of Seller's or its Wholly Owned Subsidiary's defined benefit pension plan and of the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan as of Closing, all as measured the actuaries currently engaged by such plans; *provided*, further, that when calculating the Accumulated Benefit Obligation for the Connecticut Health Care Associates Pension Plan, the actuary shall use a discount rate equal to seven and one-half percent (7.5%);

(134) **WARN Act** is defined in Section 3.20(e); and

(135) **Wholly Owned Subsidiary** means, with respect to any Person, (i) any corporation 100% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Wholly Owned Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Wholly Owned Subsidiaries of such Person has a 100% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Wholly Owned Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (a) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (b) whose sole member is such Person.

1.02. Certain References. As used in this Agreement:

[3] Subject to due diligence

(a) references to "*this Agreement*" mean this Agreement, as amended from time to time, and all Exhibits and Schedules attached to or referenced in this Agreement;

(b) references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Agreement, unless the context states or implies otherwise;

(c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

(d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

(e) references to "*partnerships*" include general and limited partnerships;

(f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Eastern Time;

(i) references to "*Seller's Knowledge,*" "*Knowledge of Seller,*" or words of similar intent or effect mean and refer to (x) all matters with respect to which Seller or any of its Wholly Owned Subsidiaries has received written notice, and (y) the knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02(i), after due inquiry by Seller (or Wholly Owned Subsidiary, as applicable) of such Persons;

(j) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(k) the Table of Contents, the division of this Agreement into Articles and Sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this Agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this Agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller and its Wholly Owned Subsidiaries[4] in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

[4] Subject to due diligence

(a) all Owned Real Property, including the real property described on Schedule 2.01(a);

(b) all Leased Real Property, to the extent assignable or transferrable, including the real property described on Schedule 2.01(b);

(c) all of the tangible personal property owned or leased by Seller and its Wholly Owned Subsidiaries[5] or used in the conduct of the Hospital Businesses, including all equipment (including medical and computer equipment located at the Hospital), vehicles, furniture and furnishings and other tangible personal properties, a current list and the general location of which are set forth on Schedule 2.01(c)(i); *provided* that any such leased personal property shall be described on Schedule 2.01(c)(ii);

(d) all current assets not otherwise specifically described above or below in this Section 2.01 that are included in Net Working Capital;

(e) to the extent transferable, all financial, patient, medical staff, personnel and other records of the Hospital Businesses, including, but not limited to, all documents, records, operating manuals, files, and computer software with respect to the operation of the Hospital Businesses, including, without limitation, all patient records, medical records, employee records, financial records, equipment records, construction plans and specifications, medical and administrative libraries, operating manuals, proprietary manuals, marketing materials, policy and procedure manuals, files, documents, records, books, catalogs, data, and studies or analyses;

(f) all rights and interest, to the extent assignable or transferable, with respect to the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), and the leases relating to the leased personal property listed or described on Schedule 2.01(c), and all Immaterial Contracts not listed or described on Schedule 2.02(p) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits, to the extent legally assignable, including those Permits described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and all goodwill associated therewith, and the Information Systems;

(i) all property of Seller and its Wholly Owned Subsidiaries, real, personal or mixed, tangible or intangible, arising or acquired between the date of this Agreement and the Closing Date;

(j) all usable inventories of supplies, drugs, food, janitorial and office supplies, and other disposables and consumables located at the Hospital Businesses, or

[5] Subject to due diligence

used with respect to the operation of the Hospital Businesses (the term "usable" in this clause meaning non-obsolete or slow moving and consumable within the ordinary course of business of the Hospital Businesses, consistent with past practices);

(k) all claims of Seller and its Wholly Owned Subsidiaries against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, except for those claims described on Schedule 2.02(n) and any claims relating to Excluded Assets or the Excluded Liabilities;

(l) general intangibles of the Hospital Businesses, including goodwill;

(m) all advance payments, prepayments, prepaid expenses, deposits, and the like that were made with respect to the operation of the Hospital Businesses and have continuing value to the Hospital Businesses as of the Closing Date, the current categories and amounts of which are set forth on Schedule 2.01(m);

(n) Seller's and its Wholly Owned Subsidiaries' provider agreements with third-party payors, including, but not limited to, Government Payment Programs;

(o) the electronic funds transfer account of the Hospital Businesses (the "**EFT Account**") (other than any cash in such EFT Account at Closing, which shall be an Excluded Asset) and all information necessary to access the EFT Account;

(p) all other bank accounts that receive deposits from Government Payment Programs; *provided, however*, that all funds in such accounts as of the Closing Date shall be retained by Seller;

(q) all of Seller's stock, partnership, membership, or other ownership interests, to the extent assignable or transferable and not inconsistent with Legal Requirements, in each of the Joint Ventures and Converted Ventures (the "**JV Interests**"), but only to the extent that the governing instruments thereof and Legal Requirements permit such transfer, together with all minutes and other records relating to such entities that are in the possession of Seller as of the Closing Date;

(r) to the extent assignable by Seller, all warranties (express or implied) and rights and claims assertable by (but not against) Seller and its Wholly Owned Subsidiaries related to the Assets;

(s) all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or its Wholly Owned Subsidiaries or payable to Seller or its Wholly Owned Subsidiaries, and all deductibles, copayments and self-insurance requirements payable by Seller or its Wholly Owned Subsidiaries) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(t) all other property, other than the Excluded Assets, of every kind, character, or description owned by Seller or its Wholly Owned Subsidiaries, whether

or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other businesses and ventures owned by Seller or its Wholly Owned Subsidiaries; and

(u) all proceeds of the foregoing.

Seller shall convey good and marketable title to the Assets and all parts thereof to Buyer, free and clear of all claims, assessments, security interests, liens, restrictions, and encumbrances, other than the Permitted Encumbrances and the Assumed Liabilities.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in Section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this Agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

(a) all cash, cash equivalents, and short-term and long-term Investments, including cash in the EFT Account as of the Closing Date, but, for the avoidance of doubt, excluding the JV Interests transferred pursuant to Section 2.01;

(b) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and investments restricted as to use), trusts related to employee benefits, amounts reserved in connection with any unfunded Employee Benefit Plans listed in Section 3.21 that do not have a trust, trusts related to self-insurance, donor-restricted assets, beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(c) all intercompany receivables of Seller with any of its Affiliates or Wholly Owned Subsidiaries;

(d) all other current financial assets not included in Net Working Capital;

(e) [any asset that would revert to the employer upon the termination of any of the Employee Benefit Plans, including assets representing a surplus or overfunding of any such plans][6];

(f) all rights to refunds, credits, deposits, prepayments, or the equivalent owing to Seller from any taxing authority with respect to periods prior to the Closing Date, and the right to pursue appeals of same;

(g) the taxpayer and other identification numbers, seals, minute books, corporate records, and other documents relating to the organization, maintenance, and existence of Seller and its Wholly Owned Subsidiaries;

[6] Subject to due diligence

(h) all claims, rights, interests, and proceeds (whether received in cash or by credit to amounts otherwise due to a third party) with respect to amounts overpaid with respect to the Hospital Businesses to any third party with respect to periods prior to the Closing Date;

(i) all bank accounts relating to the Hospital Businesses, other than the EFT Account and any other account that receives payments from Government Payment Programs;

(j) all writings and other items that are protected from discovery by the attorney-client privilege, the attorney work product doctrine, or any other cognizable privilege or protection of Seller or its Wholly Owned Subsidiaries;

(k) any Cost Report settlement receivables of Seller or its Wholly Owned Subsidiaries for periods ended on or prior to the Closing Date;

(l) any assets owned and provided by vendors of goods or services to the Hospital Businesses, possession of which will be retained by the Hospital Businesses;

(m) unclaimed property of any third party in respect of the operation of the Hospital Businesses, including, without limitation, property that is subject to applicable escheat laws;

(n) all rights, claims, and choses in action of Seller against third parties in respect of the operation of the Hospital Businesses with respect to periods prior to the Closing Date described on Schedule 2.2(n), and any payments, awards, or other proceeds resulting therefrom;

(o) all interests in, and assets related to, Children's Center of Greater Waterbury Health Network, Inc. and Healthcare Alliance Insurance Company, Ltd.;

(p) the name "Waterbury Hospital Foundation";

(q) all rights and interests of Seller in and to the commitments, contracts, leases, and agreements other than the Assumed Contracts, including the commitments, contracts, leases and agreements set forth on Schedule 2.02(p) (collectively, the "**Excluded Contracts**");

(r) [all physician loans and receivables][7];

(s) all insurance proceeds with respect to the Assets (including insurance proceeds received by Seller or its Wholly Owned Subsidiary or payable to Seller or its Wholly Owned Subsidiary) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent all damage to the Assets has been repaired by Seller;

[7] Subject to due diligence

(t) the portions of inventory, prepaid expenses and the like, and other Assets disposed of, expended, or canceled, as the case may be, by the Hospital Businesses prior to the Closing Date in the ordinary course of business; and

(u) any other assets identified in Schedule 2.2(t).

2.03. Assumed Liabilities. In connection with the conveyance of the Assets to Buyer, Buyer shall assume, effective as of the Closing Date, the future payment and performance of the following liabilities (the "**Assumed Liabilities**") of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses:

(a) all obligations accruing after the Closing Date with respect to the Assumed Contracts or the Leased Personal Property;

(b) the trade accounts payable and current liabilities of the Hospital Businesses as of the Closing Date, but only to the extent such accounts payable and current liabilities are included in the calculation of Net Working Capital;

(c) obligations and liabilities as of the Closing Date in respect of accrued paid time off benefits of employees of Seller or its Wholly Owned Subsidiaries of the Hospital Businesses who are hired by Buyer as of the Closing Date, and related Taxes, but only to the extent such accrued paid time off benefits, and related taxes, are included in Net Working Capital;

(d) the Capital Lease Obligations;

(e) Tax liabilities or obligations in respect of the Hospital Businesses and the Assets with respect to periods commencing on or after the Closing Date;

(f) the Asbestos Abatement Liability;

(g) any liability owed or due and owing with respect to periods on or after the Closing Date with respect to any Employee Benefit Plan listed on Schedule 2.03(g); and

(h) claims or potential claims for medical malpractice or general liability relating to events that occurred or arose prior to the Closing Date, but which are made or asserted against any of the Hospital Businesses, Joint Ventures, or Converted Ventures for the first time after the Closing Date and where such claim (or the circumstances' surrounding such claim) could not have been properly reported by such Hospital Businesses, Joint Ventures, or Converted Ventures to their respective insurance carrier(s) on or prior to the Closing Date.

Buyer shall not be liable for (i) any claims arising from Seller's or its Wholly Owned Subsidiaries' assignment and Buyer's assumption of the Assumed Liabilities; (ii) uncured defaults in the performance of the Assumed Liabilities for periods prior to the Closing Date; (iii) unpaid amounts in respect of the Assumed Liabilities that are due as of the Closing Date (that are not reflected in Net Working Capital or the Capital Lease Obligations); and/or (iv) rights or

remedies claimed by third parties under any of the Assumed Liabilities that broaden or vary the rights and remedies such third parties would have had against Seller, its Wholly Owned Subsidiaries and the Hospital Businesses if the sale and purchase of the Assets were not to occur.

2.04. Excluded Liabilities. Except for the Assumed Liabilities, the Buyer shall not assume and under no circumstances shall the Buyer be obligated to pay or assume, and none of the assets of Buyer shall be or become liable for or subject to, any liability, indebtedness, commitment, or obligation of Seller or its Wholly Owned Subsidiaries, whether known or unknown, fixed or contingent, recorded or unrecorded, currently existing or hereafter arising or otherwise (collectively, the "**Excluded Liabilities**"), including, without limitation, the following Excluded Liabilities:

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

(b) claims or potential claims for medical malpractice or general liability relating to events that occurred or arose prior to the Closing Date, but which are made or asserted against any of the Hospital Businesses, Joint Ventures, or Converted Ventures for the first time prior to the Closing Date, and any such claim made or asserted before or after the Closing Date, where such claim (or the circumstances surrounding such claim) could have properly been reported by such Hospital Businesses, Joint Ventures, or Converted Ventures to their respective insurance carrier(s) on or prior to the Closing Date;

(c) those claims and obligations (if any) specified in Schedule 2.04 hereto;

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

(e) liabilities or obligations associated with indebtedness for borrowed money (other than Capital Lease Obligations);

(f) liabilities and obligations of Seller or its Wholly Owned Subsidiaries in respect of the Hospital Businesses with respect to periods prior to the Closing Date arising under the terms of Government Payment Programs or other third party payor programs, and any liability arising pursuant to Government Payment Programs or other third party payor programs as a result of the consummation of any of the transactions contemplated under this Agreement, including, for the avoidance of doubt, all Medicare and Medicaid Cost Reports, DSH payments or other settlements for all periods prior to the Closing Date;

(g) Taxes incurred by the Hospital Businesses with respect to periods prior to the Closing Date (*provided, however*, that this clause (g) shall not apply to any and all Taxes payable with respect to any employee benefits constituting Assumed Liabilities under Section 2.03(c) hereof and any Taxes constituting Assumed Liabilities under Section 2.03(e) hereof);

(h) liability for any and all claims by or on behalf of employees of Seller or its Wholly Owned Subsidiaries relating to periods prior to the Closing Date, including,

without limitation, liability for any pension, profit sharing, deferred compensation, or any other employee health and welfare benefit plans, liability for any Equal Employment Opportunity Commission claim, Americans with Disability Act claim, Family and Medical Leave Act claim, wage and hour claim, unemployment compensation claim, or workers' compensation claim, and any liabilities or obligations to former employees of Seller or its Wholly Owned Subsidiaries under COBRA (*provided, however*, that this clause (i) shall not apply to any and all employee benefits constituting Assumed Liabilities under Section 2.03(g) hereof);[8]

(i) any obligation or liability accruing, arising out of, or relating to any federal, state, or local investigations of, or claims or actions against, Seller or its Wholly Owned Subsidiaries, the Hospital Businesses, or any of their employees, medical staff, agents, vendors, or representatives with respect to acts or omissions prior to the Closing Date;

(j) any civil or criminal obligation or liability accruing, arising out of, or relating to any acts or omissions of Seller, its Wholly Owned Subsidiaries, or their directors, officers, employees, representatives, and agents claimed to violate any Legal Requirements of any Governmental Authority arising out of acts occurring before the Closing Date;

(k) liabilities or obligations arising as a result of any breach by Seller or its Wholly Owned Subsidiaries or the Hospital Businesses at any time of any Excluded Contract;

(l) liabilities or obligations arising out of any breach by Seller or its Wholly Owned Subsidiaries or the Faclities prior to the Closing Date of any Assumed Contract;

(m) any obligation or liability asserted under the federal Hill-Burton Act or other restricted grant and loan programs with respect to the ownership or operation of the Hospital Businesses or the Assets;

(n) any debt, obligation, expense, or liability of Seller or its Wholly Owned Subsidiaries arising out of or incurred solely as a result of any transaction occurring after the Closing Date or for any violation by Seller or its Wholly Owned Subsidiaries of any law, regulation, or ordinance at any time (including, without limitation, those pertaining to fraud, environmental, health care regulatory, and ERISA matters);

(o) all liabilities and obligations relating to any oral agreements, oral contracts, or oral understandings, including those with any referral sources, including, but not limited to, physicians, unless reduced to writing and expressly assumed as part of the Assumed Contracts;

(p) any liability arising out of the act of assignment of any of the Assumed Contracts to Buyer at the Closing;

[8] Subject to due diligence

(q) the obligations and liabilities arising in connection with Transfer Act; and

(r) all workers' compensation liabilities of Seller and its Wholly Owned Subsidiaries.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and its Wholly Owned Subsidiaries and tender the purchase price, determined as follows (the "**Purchase Price**"), subject to the adjustments described in Section 2.05(g):

(i) $31,800,000, *plus*

(ii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds the Target Net Working Capital, or *minus*

(iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than the Target Net Working Capital, and *minus*

(iv) the amount of the Capitalized Lease Obligations in excess of $6,500,000, and *minus*

(v) the Unfunded Pension Liabilities, which shall be calculated as of the Closing Date, and *minus*

(vi) the Asbestos Abatement Liability, and *minus*

(vii) the amount of liabilities listed on Schedule 2.05(a)(vii).[9]

(b) Notwithstanding the foregoing Section 2.05(a), no liabilities of Seller or its Wholly Owned Subsidiaries shall be subtracted from the Purchase Price to the extent any such liabilities are already included in Net Working Capital.

(c) The Purchase Price, including estimates at Closing of the Net Working Capital and the Unfunded Pension Liabilities, will be calculated as follows.

(i) For purposes of determining the Purchase Price, not more than five (5) but in no event less than two (2) business days prior to the Closing, Seller shall deliver to Buyer a statement setting forth its good faith estimate as of the Closing Date of the (a) Net Working Capital and (b) Unfunded Pension Liabilities, including supporting documentation of reasonable specificity and other information requested by the Buyer to verify such amounts.

[9] TBD based on due diligence – may be "none"

(ii) The estimate of Net Working Capital at Closing will be calculated by Seller from the physical count of Seller's inventory for its September 30, 2015 audit and its ensuing customary perpetual inventory, the relevant entries in the Interim Closing Balance Sheets and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06. The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on Seller's perpetual inventory system and valued in Seller's customary manner. The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer.

(iii) The estimate of Unfunded Pension Liabilities at Closing will be calculated by Seller from the Interim Closing Balance Sheets and/or the then most recently updated actuarial analyses.

(d) At Closing, Buyer shall pay such Purchase Price (based on the estimate provided by Seller pursuant to Section 2.05(c)) by wire transfer of immediately available funds to an account designated by the Seller to Buyer prior to the Closing Date, and Seller shall immediately use whatever portion of the Purchase Price is necessary to pay off all indebtedness of Seller (other than Capitalized Lease Obligations assumed by Buyer), including the indebtedness under the Loan Agreement.

(e) Not more than ninety (90) days after the Closing, Buyer shall prepare and deliver, or cause to be prepared and delivered, to Seller, the final closing statement (the "**Final Closing Statement**") setting forth (i) its good faith determination of the actual Net Working Capital as of the Closing Date (based on the Closing Balance Sheets), (ii) a calculation showing the difference between the Net Working Capital estimated by Seller at Closing and the actual Net Working Capital as of the Closing Date, (iii) its good faith determination of the actual Unfunded Pension Liabilities as of the Closing Date (as determined by the actuaries then serving those pension plans), and (iv) a calculation showing the difference between the Unfunded Pension Liabilities estimated by Seller at Closing and the actual Unfunded Pension Liabilities (as determined by the actuaries then serving those pension plans) as of the Closing Date. Except as otherwise provided herein, the Final Closing Statement and the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable, Unfunded Pension Liabilities, contractual allowances and doubtful accounts, as used in preparing the Audited Financial Statements, except as otherwise provided in this Agreement.

(f) Following receipt of the information set forth in Section 2.05(e), Seller will be afforded a period of twenty (20) business days (the "**20-Day Period**") to review the Final Closing Statement and the Closing Balance Sheets. At or before the end of the 20-Day Period, Seller will either (i) accept the amount of the actual Net Working Capital and Unfunded Pension Liabilities calculated by Buyer in their entirety or (ii) deliver to Buyer a written notice (the "**Objection Notice**") containing a reasonably detailed written explanation of those items on the Final Closing Statement or the Closing Balance Sheets that Seller disputes, in which case the items specifically identified by Seller shall be

deemed to be in dispute. The failure by Seller to deliver the Objection Notice within the 20-Day Period shall constitute Seller's acceptance of the amount of the actual Net Working Capital and Unfunded Pension Liabilities calculated by Buyer. If Seller delivers the Objection Notice in a timely manner, then, within a further period of twenty (20) business days from the end of the 20-Day Period (the "**Second 20-Day Period**"), the parties will attempt to resolve in good faith any disputed items and reach a written agreement (the "**Settlement Agreement**") with respect thereto. Failing such resolution, as promptly as practicable (and no event later than ten (10) business days from the end of the Second 20-Day Period), the unresolved disputed items will be referred for final binding resolution to Deloitte (the "**Arbitrating Accountants**"). In resolving any disputed item, the Arbitrating Accountants may not assign a value to any item greater than the greatest value for such item claimed by either party or less than the smallest value for such item claimed by either party. The fees and expenses of the Arbitrating Accountants shall be allocated between Buyer and Seller in proportion to the amounts by which their proposals of the actual Net Working Capital and Unfunded Pension Liabilities differed from the Arbitrating Accountants' final determination. Such determination (the "**Accountants' Determination**") shall be (i) in writing, (ii) furnished to the Buyer and Seller as soon as practicable (and in no event later than thirty (30) business days) after the items in dispute have been referred to the Arbitrating Accountants, (iii) made in accordance with GAAP, consistently applied, and (iv) non-appealable and incontestable by Buyer or Seller and each of their respective Affiliates and successors and assigns and not subject to collateral attack for any reason other than manifest error or fraud.

(g) The Purchase Price will be recalculated (based on clauses (i), (ii) and (iii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(c)(ii) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) estimated at Closing and the actual Net Working Capital as of the Closing Date (based on the Closing Balance Sheets), and (iii) the difference between the Unfunded Pension Liabilities estimated at Closing and the actual Unfunded Pension Liabilities (based on the Closing Balance Sheets).

(h) Within five (5) business days following the Final Determination Date, Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay the Seller (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient. In the event that Seller is required to pay Buyer pursuant to this Section 2.05(h), and payment is not made in full by Seller within five (5) business days following the Final Determination Date, Buyer shall be entitled, but shall not be obligated, to apply an amount equal to the shortfall in such payment against the Indemnification Holdback Amount, in accordance with Section 10.09(a).

2.06. Prorations. At Closing, and to the extent not included in Net Working Capital, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Person that is a non-profit corporation that does not pay any property Taxes with respect to such property) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer upon Buyer's receipt of such credit.

2.07. Disclaimer of Warranties. Subject to the representations and warranties set forth in this Agreement, including, but not limited to, those set forth in Article 3, and except as expressly set forth in the Closing Documents, the Assets transferred to the Company and any Buyer will be transferred in their physical condition at the Effective Time, "AS IS, WHERE IS, AND WITH ALL FAULTS AND NONCOMPLIANCE WITH LAWS," and with respect to the Real Property, land, buildings, and improvements, WITH NO WARRANTY OF HABITABILITY OR FITNESS FOR HABITATION, and with respect to the physical condition of the personal property and the inventory and supplies, WITH NO WARRANTIES, INCLUDING, WITHOUT LIMITATION, THE WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer and PMH on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Seller is a non-stock corporation duly organized and validly existing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct the Hospital Businesses as now being conducted, to enter into this Agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this Agreement and the Closing Documents to which Seller is or becomes a party, and the consummation by Seller of the transactions contemplated by this Agreement:

(a) are within its corporate powers, are not in contravention of law or of the terms of its organizational documents, and have been duly authorized by all appropriate corporate action;

(b) except as provided in Section 5.05 below, do not require any approval or consent of, or filing with, any Governmental Authority bearing on the validity of this

Agreement that is required by Legal Requirements of any such Governmental Authority;

(c) except as set forth in Schedule 3.02(c), will neither conflict with, nor result in any breach or contravention of, or the creation of any lien, charge, or encumbrance under, or permit the acceleration of the maturity of, any indenture, agreement, lease, instrument, or understanding to which it is a party or by which it is bound, except for such breaches or contraventions that may result from the failure to obtain the consent of the counterparty thereto in connection with the assignment of any Assumed Contract to the Buyer and for which Seller remains liable;

(d) will not violate any material Legal Requirements of any Governmental Authority to which it or the Assets may be subject; and

(e) will not violate any judgment, decree, writ, or injunction of any court or Governmental Authority to which it or the Assets may be subject.

3.03. Binding Agreement. This Agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof.

3.04. Investments and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material assets, or any interest therein, of Seller, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Buyer with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance.

(a) Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.05(a) or as set forth on Schedule 3.05(a), the operations of the Hospital Businesses are in compliance in all material respects with all applicable Legal Requirements of Governmental Authorities having jurisdiction over the Hospital Businesses and the operations of the Hospital or its related ancillary services. Seller and its Wholly Owned Subsidiaries have timely filed all reports, data, and other information required to be filed with any Governmental Authorities. Neither Seller nor its Wholly Owned Subsidiaries, nor any of its officers, directors, agents, or employees thereof, has committed a violation of federal or state laws regulating health care fraud, including but not limited to the federal Anti-Kickback Law, 42 U.S.C. §1320a-7b, the Stark Laws, 42 U.S.C. §1395nn, as amended, and the False Claims Act, 31 U.S.C. §3729, et seq. Seller and its Wholly Owned Subsidiaries are in compliance in all material respects with the administrative simplification provisions required under HIPAA, including the electronic data interchange regulations and the health care privacy

regulations. Seller and its Wholly Owned Subsidiaries have not received notice of any claim, Proceeding, or investigation alleging or based upon an alleged material violation of any Legal Requirements.

(b) Seller has provided to Buyer a copy of the Hospital's current compliance program materials, including, without limitation, all program descriptions, compliance officer and committee descriptions, ethics and risk area policy materials, training and education materials, auditing and monitoring protocols, reporting mechanisms, and disciplinary policies. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.05(b) or to the extent set forth on Schedule 3.05(b), Seller (or any Wholly Owned Subsidiary thereof) (a) is not a party to a Corporate Integrity Agreement with the Office of Inspector General of the United States Department of Health and Human Services, (b) has no reporting or other continuing obligations pursuant to any settlement or other agreement entered into with any Government Authority (other than participation agreements with Government Payment Programs), (c) to the Knowledge of Seller, has not been the subject of any Government Payment Program investigation conducted by any federal or state enforcement agency within the past three (3) years, (d) has not been a defendant in any unsealed *qui tam*/False Claims Act litigation within the past three (3) years, (e) has not been served with or received, within the past three (3) years, any search warrant, subpoena, civil investigative demand, or contact letter by or from any Government Authority (except in connection with medical services provided to third parties who may be defendants or the subject of investigation into conduct unrelated to the operations of the health care businesses conducted by the Hospital Businesses), and (f) has not received any complaints within the past three (3) years from employees, independent contractors, vendors, physicians, or any other person that would indicate that Seller (or any Wholly Owned Subsidiary thereof) has violated any Legal Requirements. Schedule 3.05(b) includes a description of each audit and investigation conducted by Seller at the Hospital pursuant to its compliance program during the past three (3) years. For purposes of this Agreement, the term "compliance program" refers to provider programs of the type described in the compliance guidance published by the Office of Inspector General of the Department of Health and Human Services.

3.06. Financial Statements; Undisclosed Liabilities. Seller has delivered to Buyer copies of the following financial statements (collectively, the "**Financial Statements**"), which Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 3.06:

(a) Unaudited balance sheet dated as of _____, 2015 (the "**Balance Sheet Date**");

(b) Unaudited income statement for the _____-month period ended on the Balance Sheet Date; and

(c) Audited Financial Statements.

Such unaudited Financial Statements conform to GAAP consistently applied, except as set forth on Schedule 3.06. Such audited Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such balance sheets present fairly the financial condition of Seller as of the dates indicated thereon, and such income statements included in the Financial Statements present fairly the results of operations of Seller for the periods indicated thereon. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses, Joint Ventures or Converted Ventures, or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in Financial Statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the Balance Sheet Date, and none of which could reasonably be expected to result, individually or in the aggregate, in a material adverse effect.

3.07. Recent Activities. Except as set forth in Schedule 3.07, with respect to Seller or its Wholly Owned Subsidiaries, since the Balance Sheet Date there has not been any:

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

(b) material adverse change in the condition, financial or otherwise, of the Hospital Businesses or the Assets, including, but not limited to, the business or prospects of the Hospital Businesses or the results of operations of the Hospital Businesses;

(c) threatened employee strike, material work stoppage, or material labor dispute pertaining to the Hospital Businesses;

(d) sale, assignment, transfer, or disposition of any item of property, plant, or equipment included in the Assets and having a net book value in excess of Seventy-Five Thousand Dollars ($75,000) (other than supplies), except in the ordinary course of business with comparable replacement thereof;

(e) sale, factor or disposition of, or agreement to sell, factor or dispose of, any accounts receivable;

(f) any general increase in the compensation payable to any of its or their employees or independent contractors or any increase in, or institution of, any bonus, severance, insurance, pension, profit-sharing or other employee benefit plan, remuneration, or arrangements made to, for, or with such employees;

(g) dividend, distribution, or extraordinary payment;

(h) change in the composition of the medical staff of the Hospital Businesses, other than normal turnover occurring in the ordinary course of business;

(i) change in the rates charged by the Hospital Businesses for their services, other than those made in the ordinary course of business;

(j) adjustment or write-off of accounts receivable or reduction in reserves for accounts receivable outside the ordinary course of business;

(k) change in the accounting methods or practices, including the methods used to estimate contractual allowances or doubtful accounts, other than those required by any changes in GAAP, or change in depreciation or amortization policies;

(l) encumbrance or lien that has been imposed on any of the Assets;

(m) cancellation or waiver of any material rights in respect of the Assets, except in the ordinary course of business;

(n) other than compensation paid in the ordinary course of employment, sale of any Assets to, or execution of any contract or agreement with, any officer, director or trustee of Seller, or with any Affiliate of any such person or entity;

(o) payment or agreement to pay to any Person any damages, fines, penalties or other amounts in excess of $25,000 individually or $100,000 in the aggregate in respect of an actual or alleged violation of any Legal Requirement; or

(p) transaction outside the ordinary course of business.

3.08. Accounts Receivable; Inventory.

(a) All Accounts Receivable constituting a part of the Assets represent and constitute bona fide indebtedness owing to Seller (or any Wholly Owned Subsidiary thereof) for services actually performed or for goods or supplies actually provided in the amounts indicated on the Financial Statements with no known Encumbrances, set-offs, deductions, compromises, or reductions (other than reasonable allowances for bad debts and contractual allowances in an amount consistent with historical policies and procedures of Seller and that are taken into consideration in the preparation of the Financial Statements). Seller has made available to Buyer a complete and accurate aging report of all such Accounts Receivable and a schedule of all Accounts Receivable that have been assigned to collection agencies or are otherwise held or assigned for collection.

(b) The inventory and supplies constituting part of the Assets are substantially of a quality and quantity usable and salable in the ordinary course of business of the Hospital Businesses. Obsolete items have been written off the Financial Statements. Inventory and supplies are carried at cost, on a first-in, first-out basis, and are properly stated in the Financial Statements in accordance with GAAP. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.09. Equipment. Seller has delivered to Buyer a fixed asset listing and depreciation schedule as of the Balance Sheet Date (Schedule 3.09) that takes into consideration all the equipment associated with, or constituting any part of, the Hospital Businesses and the Assets.

All major items of equipment are useable for their intended purpose in the ordinary course of business and are in working condition, subject to reasonable wear and tear.

3.10. Title. Except as provided in Schedule 3.10, Seller or its Wholly Owned Subsidiary, as applicable, owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Permitted Encumbrances and Assumed Liabilities.

3.11. Real Property.

(a) Seller or its Wholly Owned Subsidiary, as applicable, owns good and marketable fee simple and/or leasehold title, as the case may be, to the Real Property, together with all buildings, improvements, and component parts thereon and all appurtenances and rights thereto. The Real Property will be conveyed to the Buyer free and clear of any and all Encumbrances other than the Permitted Encumbrances set forth on Schedule 3.11(a).

(b) With respect to the Real Property, except as set forth in Schedule 3.11(b):

(i) Neither Seller nor any Wholly Owned Subsidiary has received during the past five (5) years written notice of a violation of any applicable Legal Requirement;

(ii) The Owned Real Property, and, to Seller's Knowledge, Leased Real Property, and its operation are in compliance in all material respects with all applicable zoning ordinances, and the consummation of the transactions contemplated herein will not result in a violation of any applicable zoning ordinance or the termination of any applicable zoning variance now existing, and the buildings and improvements constituting the Real Property comply in all material respects with all building codes;

(iii) The Owned Real Property and, to Seller's Knowledge, Leased Real Property, is subject to no easements, restrictions, ordinances, or other limitations on title that could make such property unusable for its current use or the title uninsurable or unmarketable or that materially restrict or impair the use, marketability, or insurability of the Real Property other than the Permitted Encumbrances;

(iv) All of the Owned Real Property, and, to Seller's Knowledge, Leased Real Property, currently in use for the operations of the Hospital Businesses is in compliance in all material respects with the applicable provisions of the Rehabilitation Act of 1973, Title III of the Americans with Disabilities Act, and the provisions of any comparable state statute relative to accessibility (these laws are referred to, collectively, as the "**Accessibility Laws**"), and there is no pending, noticed, or, to the Knowledge of Seller, threatened litigation, administrative action, or complaint (whether from a state, federal, or local government or from any other person, group, or entity) relating to compliance of any of the Real Property with the Accessibility Laws;

(v) There are no tenants or other persons or entities occupying any space in the Owned Real Property other than pursuant to tenant leases described in Schedule 3.11(b), and no tenants have paid rent in advance for more than one month and no rebate, concession, improvement credit or other tenant allowance of any nature is owed to any tenant, nor is any landlord improvement work required, except as disclosed in Schedule 3.11(b);

(vi) All material obligations of Seller or any Wholly Owned Subsidiary as landlord required to be performed under each of the tenant leases have been performed;

(vii) Attached to Schedule 3.11(b) is a "rent roll" that sets forth for those leases where Seller or any Wholly Owned Subsidiary in respect of the Hospital Businesses is landlord, which contains: (i) the names of then current tenants; (ii) the rental payments for the then current month under each of the leases; (iii) a list of all then delinquent rental payments; (iv) a list of all concessions granted to tenants; (v) a list of all tenant deposits and a description of any application thereof, and (vi) a list of all uncured material defaults under the leases known to Seller or its Wholly Owned Subsidiaries;

(viii) Seller or any Wholly Owned Subsidiary has not received written notice of condemnation or of any special assessment relating to any part of the Real Property, of any existing or proposed plans to modify or realign any street or highway, or any existing or proposed eminent domain proceeding by any Government Authority that would result in the taking of all or any part of the Real Property or that would adversely affect the current use of any part of the Real Property;

(ix) All permanent certificates of occupancy and all other material licenses, permits, authorizations, consents, certificates, and approvals required by all Government Authorities having jurisdiction and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions) have been issued for the Owned Real Property (and all individual items constituting the Owned Real Property), for their current uses, have been paid for, are in full force and effect, and will not be invalidated, violated, or otherwise adversely affected by the transfer of the Real Property to the Buyer; and

(x) To the Knowledge of Seller, water, sanitary sewer, storm sewer, drainage, electric, telephone, gas, and other public utility systems are available to the Real Property, as currently developed, and are directly connected to the lines and/or other facilities of the respective public authorities or utility companies providing such services or accepting such discharge, either adjacent to the Real Property or through easements or rights of way appurtenant to and forming a party of the Real Property; and, with respect to the Owned Real Property, to the Knowledge of Seller, such easements or rights-of-way have been fully granted, all charges therefor have been fully paid by Seller or its Wholly Owned Subsidiaries, and all charges for the aforesaid utility systems and the connection of the Owned

Real Property to such systems, including without limitation connections fees, "tie-in" charges, and other charges now or hereafter to become due and payable, have been fully paid by Seller or its Wholly Owned Subsidiaries; and the water and sanitary sewer service described above is supplied by public authority.

3.12. Environmental Laws. Except as set forth on Schedule 3.12 hereto, (i) the Owned Real Property is not subject to any material environmental hazards, risks, or liabilities, (ii) neither Seller or its Affiliates, nor its Wholly Owned Subsidiaries, is in material violation of any and all Legal Requirements pertaining to the protection of human health and safety or the environment (collectively, "**Environmental Laws**"), including, without limitation, the Comprehensive Environmental Response Compensation and Liability Act, as amended ("**CERCLA**"), the Resource Conservation and Recovery Act, as amended ("**RCRA**"), and the Atomic Energy Act of 1954, as amended ("**AEA**"), and (iii) neither Seller nor any Affiliate thereof has received notice alleging or asserting either a violation of any Environmental Law or an obligation to investigate, assess, remove, or remediate any property, including but not limited to the Owned Real Property, under or pursuant to any Environmental Law. Except as set forth on Schedule 3.12, to the Knowledge of Seller, no Hazardous Substances have been, and through the Closing Date will be, disposed of on or released or discharged from or onto, or threatened to be released from or onto, the Owned Real Property (including groundwater) by Seller, or to Seller's Knowledge, any third party, in violation of any applicable Environmental Law. Except as set forth on Schedule 3.12, neither Seller or its Wholly Owned Subsidiaries nor, to Seller's Knowledge, any prior owners, operators, or occupants of the Owned Real Property, have allowed any Hazardous Substances to be discharged, processed, or otherwise released on the Owned Real Property in a manner that is in violation of any Environmental Law, and Seller and its Wholly Owned Subsidiaries has complied in all material respects with all Environmental Laws applicable to any part of the Real Property. The Hospital Businesses contain asbestos-containing material. Schedule 3.12 lists numerous reports, correspondence, operation and maintenance manuals, and other documents related to the asbestos-containing materials. These documents do not individually or collectively constitute a comprehensive asbestos survey of the Hospital Businesses or the Owned Real Property. Without in any way limiting the generality of the foregoing, to the Knowledge of Seller: (i) all current or former underground storage tanks located on the Owned Real Property and information in Seller's possession relating to the capacity, uses, dates of installation, and contents of such tanks located on the Owned Real Property are identified in the environmental reports listed on Schedule 3.12; (ii) there are not now, nor have there ever been, any collection dumps, pits, and disposal facilities or surface impoundments located on the Owned Real Property for the containment of Hazardous Substances except as identified in Schedule 3.12; and (iii) all existing underground storage tanks have been maintained in material compliance with all Environmental Laws. Except as set forth on Schedule 3.12, Seller or its Wholly Owned Subsidiaries holds all material environmental permits required in connection with the use by Seller of the Real Property or the operation of the Hospital Businesses and, to the extent permitted by law, Seller shall cause such environmental permits to be transferred to the Buyer (with the Buyer's necessary cooperation and assistance), all of which, to Seller's Knowledge, are in good standing and are not subject to meritorious challenge. The representations and warranties made in this Section 3.12 are the exclusive representations and warranties of Seller relating to environmental matters and shall supersede any and all other Sections in this Agreement including, but not limited to, Sections 3.05, 3.11(a) and 3.15.

3.13. Intellectual Property; Information Systems. Schedule 3.13 lists and briefly describes all material Intellectual Properties currently owned or used by Seller or its Wholly Owned Subsidiaries. No proceedings have been instituted or are pending or, to the Knowledge of Seller, threatened that challenge the validity of the ownership or use by Seller or its Wholly Owned Subsidiaries of such Intellectual Properties. Neither Seller nor its Wholly Owned Subsidiaries have agreed to license to a third party any owned Intellectual Properties and have no Knowledge of the use or the infringement of any such owned Intellectual Properties by any other Person. Seller (or any Wholly Owned Subsidiary thereof) owns (or possesses adequate and enforceable licenses or other rights to use) all material Intellectual Properties and all material Information Systems used.

3.14. Insurance. Schedule 3.14 is an accurate schedule of the insurance policies or self-insurance funds maintained by Seller or its Wholly Owned Subsidiaries covering the ownership and operations of the Hospital Businesses and the Assets, including the type of insurance, policy numbers, identity of insurers, amounts, and coverage. Seller has provided to Buyer a copy of all such policies and endorsements thereto. All of such policies are in full force and effect with no premium arrearage. Seller or its Wholly Owned Subsidiary, or any Affiliates thereof, has given in a timely manner to its insurers all notices required to be given under its insurance policies with respect to all of the claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions. Seller and its Wholly Owned Subsidiaries have not (a) received any written notice or other communication from any such insurance company canceling or materially amending any of such insurance policies, and to the Knowledge of Seller, no such cancellation or amendment is threatened, or (b) failed to give any required notice or present any claim that is still outstanding under any of such policies with respect to the Hospital Businesses or any of the Assets.

3.15. Permits. Each of the Hospital Businesses is duly licensed pursuant to the applicable laws of the State of Connecticut. The pharmacies, laboratories, and all other ancillary departments located at the Hospital Businesses or operated for the benefit of the Hospital Businesses that are required to be specially licensed are duly licensed by the Connecticut Department of Public Health or other appropriate licensing agency (the "**State Health Agency**"). Seller and its Wholly Owned Subsidiaries have all material Permits that are needed or required by law to operate the business related to or affecting the Hospital Businesses or any ancillary services related thereto. Seller has delivered to Buyer an accurate list and summary description (Schedule 2.01(g)) of all such Permits owned or held by Seller or its Wholly Owned Subsidiaries relating to the ownership, development, or operation of the Hospital Businesses or the Assets, all of which are now and as of the Closing shall be in good standing, except as disclosed on Schedule 3.15. Seller and its Wholly Owned Subsidiaries have not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any Permits relating to the Hospital Businesses or any ancillary services related thereto.

3.16. Government Payment Programs; Accreditation; Payor Cost Reports.

(a) The Hospital is qualified for participation in the Government Payment Programs, has a current and valid provider contract with such programs, is in compliance with the conditions of participation in such programs, and has received all

approvals or qualifications necessary for reimbursement for the Hospital. The Hospital is duly accredited, with no contingencies, by The Joint Commission (the "**Joint Commission**") for the three (3) year period set forth on Schedule 3.16(a). A copy of the most recent accreditation letter from the Joint Commission pertaining to the Hospital has been made available to Buyer. Seller has delivered to Buyer copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction since [●], 20__. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein. The billing practices employed by the Hospital Businesses with respect to all third party payors, including Government Payment Programs and private insurance companies, have been in compliance in all material respects with all applicable laws, regulations, and policies of the Government Payment Programs and applicable Contracts of such private insurance companies. Neither Seller nor its Wholly Owned Subsidiaries has billed or received any payment or reimbursement from any such payors in excess of amounts allowed by law or contract. Neither Seller nor any of its Affiliates, officers, directors, managers, employees, or controlling shareholders is excluded from participation in the Government Payment Programs, nor has Seller or any of its Wholly Owned Subsidiaries received any notice that any such exclusion is threatened. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.16 or as set forth on Schedule 3.16(a), neither Seller nor its Wholly Owned Subsidiaries has received any notice from any of the Government Payment Programs or any other third party payor programs of any pending or threatened investigations or surveys, and, to the Knowledge of Seller, no such investigations or surveys are pending, threatened, or imminent. Seller has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to the Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made in accordance with applicable reporting deadlines and in the form and manner required by CMS and the Joint Commission, respectively. Seller has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired.

(b) Seller, or its Wholly Owned Subsidiary, has duly filed all required Cost Reports in respect of the Hospital Businesses for all the fiscal years through and including the fiscal year ended September 30, 2014. All amounts shown as due from Seller (or any Wholly Owned Subsidiaries thereof) in such Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. All of such Cost Reports accurately reflect the information required to be included thereon and such Cost Reports do not claim and neither the Hospital Businesses nor Seller (or any Wholly Owned Subsidiaries thereof) has received reimbursement in any amount in excess of the amounts provided by law or

any applicable agreement. Schedule 3.16(b) indicates which of such Cost Reports have not been audited and finally settled and a brief description of any and all notices of program reimbursement, proposed or pending audit adjustments, disallowances, appeals of disallowances, and any and all other unresolved claims or disputes in respect of such Cost Reports. Seller or its Wholly Owned Subsidiary has established adequate reserves in respect of the Hospital Businesses to cover any potential reimbursement obligations that may exist in respect of any such third party Cost Reports, and such reserves are set forth in the Financial Statements.

3.17. Agreements and Commitments. Schedule 2.01(f) sets forth the Assumed Contracts that will be assumed by the Buyer. Seller has also delivered to Buyer an accurate list (Schedule 3.17) of all material Contracts that materially affect the Hospital Businesses or the Assets, to which Seller or its Wholly Owned Subsidiary is a party or by which Seller, its Wholly Owned Subsidiaries, the Assets, or any portion thereof, is bound, including, without limitation, (a) physician agreements, professional service agreements or co-management agreements, (b) agreements with health maintenance organizations, preferred provider organizations, independent practice associations, accountable care organizations, or other alternative delivery systems, (c) joint venture or partnership agreements, (d) employment, severance or retention Contracts or any other Contracts to or with individual employees or agents, including with directors, trustees, officers, employees, or other agents of Seller or its Wholly Owned Subsidiaries, (e) Contracts materially affecting ownership of, title to, use of, or any interest in Owned Real Property or Leased Real Property, (f) equipment leases and other leases that are capital leases, (g) equipment maintenance agreements, (h) agreements with Governmental Authorities, (i) collective bargaining agreements or other Contracts to or with any labor unions, labor organizations, or other employee representatives or groups of employees, (j) loan agreements, bonds, mortgages, liens, or other security agreements, (k) Contracts relating to Intellectual Properties and Information Systems, or other like Contracts affecting the Hospital Businesses or the Assets, (l) Contracts providing for payments based in any manner on the revenues or profits of Seller or any Wholly Owned Subsidiary thereof, the Hospital Businesses or the Assets, (m) Contracts relating to data processing programs, software, or source codes utilized in connection with the Hospital Businesses or the Assets, (n) Contracts relating to the administration, operation or funding of any Employee Benefit Plan, and (o) Contracts, whether in the ordinary course of business or not, that involve future payments, performance of services, or delivery of goods or material, to or by Seller (or any of its Wholly Owned Subsidiaries), of any amount or value in excess of Fifty Thousand Dollars ($50,000) on an annual basis.

3.18. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f), Seller has made available to Buyer true and correct copies of the Assumed Contracts, and has given, and will give, the agents, employees, and representatives of Buyer access to the originals of the Assumed Contracts in its possession. Seller represents and warrants with respect to the Assumed Contracts that:

(a) The Assumed Contracts constitute valid and legally binding obligations of Seller or a Wholly Owned Subsidiary and are enforceable against Seller or such Wholly Owned Subsidiary in accordance with their terms;

(b) Each Assumed Contract constitutes the entire agreement by and between the respective parties thereto with respect to the subject matter thereof;

(c) All obligations required to be performed by Seller or its Wholly Owned Subsidiary under the terms of the Assumed Contracts have been performed, no material breach has occurred under any of the Assumed Contracts, no act or omission by Seller or its Wholly Owned Subsidiary has occurred or failed to occur that, with the giving of notice, the lapse of time, or both would constitute a material default under the Assumed Contracts, and each of such Assumed Contracts is now in full force and effect;

(d) Except as expressly set forth on Schedule 3.18, none of the Assumed Contracts requires consent to the assignment and assumption of such Contracts by Buyer;

(e) Except as expressly set forth on Schedule 3.18, the assignment of the Assumed Contracts to and assumption of such Assumed Contracts by Buyer will not result in any penalty or premium, or variation of the rights, remedies, benefits, or obligations of any party thereunder; and

(f) Except as expressly set forth on Schedule 3.18, no Assumed Contract contains a prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing.

3.19. Transactions with Affiliates. Since September 30, 2014, Seller (or any Wholly Owned Subsidiary thereof) has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller, except as set forth on Schedule 3.19 or upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.20. Employees and Employee Relations.

(a) Except as set forth on Schedule 3.20(a), all employees of the Hospital Businesses are employees of Seller or its Wholly Owned Subsidiaries, and there has not been in the last three (3) years, there is not presently pending, there is not presently threatened (to the Knowledge of Seller), and no event has occurred or circumstance exists (to the Knowledge of Seller) that could provide the basis for, (i) any strike, slowdown, picketing, work stoppage, or employee grievance process, or (ii) any proceeding against or affecting Seller or its Wholly Owned Subsidiaries relating to an alleged violation of any Legal Requirements pertaining to labor relations, including, without limitation, any charge, complaint, or unfair labor practices claim filed by an employee, union, or other person with the National Labor Relations Board or any comparable Governmental Authority, organizational activity, or other labor dispute against or affecting Seller, its Wholly Owned Subsidiaries, the Hospital Businesses, or their premises.

(b) Except as set forth in Schedule 3.20(b), with respect to the employees of Seller or its Wholly Owned Subsidiaries: (i) no collective bargaining agreement exists or is currently being negotiated by Seller or its Wholly Owned Subsidiaries; (ii) no application for certification of a collective bargaining agent is pending; (iii) no demand has been made upon Seller or its Wholly Owned Subsidiaries for recognition by a labor organization; (iv) no union representation question exists; (v) no union organizing activities are, to the Knowledge of Seller, taking place; and (vi) none of the employees of Seller or its Wholly Owned Subsidiaries is represented by any labor union or organization.

(c) Except as set forth in Schedule 3.20(c), Seller and its Wholly Owned Subsidiaries have complied in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; neither Seller, nor its Wholly Owned Subsidiaries, are liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the Knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other entity), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other entity), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.20(d) (or as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.20(d)) states the number of employees terminated by Seller or any of its Wholly Owned Subsidiaries within ninety (90) days prior to the Closing Date, laid off by Seller or any of its Wholly Owned Subsidiaries within the six (6) months prior to the Closing Date, or whose hours of work have been reduced by more than fifty percent (50%) by Seller or any of its Wholly Owned Subsidiaries in the six (6) months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours; (ii) the reason for termination, layoff, or reduction in work hours; and (iii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.20(d), neither Seller, nor its Wholly Owned Subsidiaries, has violated the Worker Adjustment and Retraining Notification Act ("**WARN Act**") or any similar state or local Legal Requirements.

(e) To the Knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller or any of its Wholly Owned Subsidiaries is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the Hospital Businesses; or (ii) to assign to Seller or to any other Person any rights to any invention, improvement, or discovery. To the Knowledge of Seller, no former or

current employee of Seller or any of its Wholly Owned Subsidiaries at the Hospital Businesses is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as heretofore carried on by Seller prior to Closing.

(f) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller, its Wholly Owned Subsidiaries or the Hospital Businesses requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To the Knowledge of Seller, no employee of Seller, its Wholly Owned Subsidiaries or the Hospital Businesses who is a foreign national has ever worked without employment authorization from the Department of Homeland Security or any other Governmental Authority that must authorize such employment and Seller have complied with applicable immigration laws with respect to the employment of foreign nationals. To the Knowledge of Seller, Seller and its Wholly Owned Subsidiaries have timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no proceedings pending or, to Seller's Knowledge, threatened against Seller or any of its Wholly Owned Subsidiaries relating to Seller's or any Wholly Owned Subsidiary's compliance with federal immigration regulations, including compliance with federal immigration laws. Except as set forth on Schedule 3.20(g), neither Seller, nor any of its Wholly Owned Subsidiaries, has received any letter from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and neither Seller, nor any of its Wholly Owned Subsidiaries, has received any letter or other correspondence from the Department of Homeland Security or other Government Authority regarding the employment authorization of any employees of Seller or its Wholly Owned Subsidiaries. If Seller or any of its Wholly Owned Subsidiaries operates in a state or has Contracts with a Governmental Authority that requires or provides a safe harbor if an employer participates in the Department of Homeland Security's e-Verify electronic employment verification system, Seller or any of its Wholly Owned Subsidiaries, as applicable, has been participating in e-Verify for the entire period such participation has been required or available as a safe harbor or as long as Seller or any such Wholly Owned Subsidiary has been operating in such state or contracting with such Governmental Authority.

(g) To the Knowledge of Seller, all employees, former employees and independent contractors of Seller or its Wholly Owned Subsidiaries have been properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state law equivalent.

3.21. Employee Benefit Plans.

(a) Schedule 3.21 contains a list of all benefit plans maintained by Seller and its Wholly Owned Subsidiaries within the last five (5) years with respect to its employees (whether tax-qualified or nonqualified, currently effective or terminated, written or unwritten) including, without limitation, any of the following:

(i) employee pension benefit plan (as defined in Section 3(2) of ERISA), including, without limitation, any pension, profit-sharing, or stock bonus plan (as described in Section 401(a) of the Code, and related provisions thereof), defined benefit plan or defined contribution plan (as defined in ERISA Sections 3(34) and 3(35)), governmental plan, or church plan;

(ii) annuity contracts purchased by Seller or its Wholly Owned Subsidiaries for employees of the Hospital Businesses in accordance with Code Section 403(b) including, without limitation, any group annuity contracts, individual annuity contracts, and custodial account arrangements under Code Section 403(b)(7), regardless of whether contributions are made to such annuity contracts on a pre-tax or after-tax basis;

(iii) employee welfare benefit plan (as defined in ERISA Section 3(1)) including, without limitation, any health (including, without limitation, medical, dental, or vision) plan, life-insurance plan, death benefit plan, short-term disability plan, long-term disability plan, accident plan, accidental death and dismemberment plan, long-term care plan, or employee assistance plan;

(iv) fringe benefit plan, including, without limitation, any specified fringe benefit plan (as defined in Code Section 6039D), cafeteria plan, or tuition assistance plan;

(v) executive compensation or incentive plan, including, without limitation, any bonus plan, incentive-compensation plan, deferred-compensation plan, non-qualified profit-sharing plan, stock-option plan, stock-appreciation-right plan, stock-bonus plan, stock-purchase plan, employee-stock-ownership plan, or savings plan;

(vi) post-termination benefits plan including, without limitation, any severance plan, change-in-control plan, supplemental-unemployment plan, layoff plan, salary-continuation plan, or non-qualified retirement plan; or

(vii) vacation, holiday, sick-leave, paid-time-off, or other employee compensation plan, procedure, program, payroll practice, policy, agreement, commitment, contract, or understanding;

and any such plan or other arrangement that (i) is maintained or contributed to by Seller or any other corporation or trade or business controlled by, controlling, or under common control with Seller (within the meaning of Code Section 414 or ERISA Sections 4001(a)(14) or 4001(b)) ("**ERISA Affiliate**"), or with respect to which Seller or any ERISA Affiliate has or may have any liability; or (ii) provides benefits, or describes a plan, procedure, program, payroll practice, policy,

agreement, commitment, contract, or understanding applicable to any current or former director, officer, employee, or individual service provider of Seller or any ERISA Affiliate, or the dependents of any thereof, regardless of how (or whether) liabilities for the provision of benefits are accrued or assets are acquired or dedicated with respect to the funding thereof. All such plans or arrangements that are set forth on Schedule 3.21 are referred to hereinafter collectively as the "**Employee Benefit Plans**."

(b) Seller has delivered to Buyer accurate and complete copies of (i) the current documents comprising each Employee Benefit Plan (or, with respect to any Employee Benefit Plan that is unwritten, a detailed written description thereof); (ii) all current trust agreements or other funding instruments related to each Employee Benefit Plan, if any; (iii) all formal rulings, letters, and opinions regarding each Employee Benefit Plan from the IRS, the DOL, PBGC, or any other Governmental Authority that pertains to each Employee Benefit Plan that have been issued within the last three (3) years and any open requests therefor; (iv) the annual reports filed with any Governmental Authority with respect to each Employee Benefit Plan during the current year and each of the three (3) preceding years, if any; (v) all current contracts with third-party administrators, consultants, and other independent contractors that relate to each Employee Benefit Plan; (vi) all current summary plan descriptions, summaries of material modifications and memoranda, and other written communications regarding each Employee Benefit Plan currently in effect, if applicable; and (vii) documents evidencing compliance with the privacy requirements under HIPAA relating to each Employee Benefit Plan, as to which such requirements apply.

(c) Except as provided on Schedule 3.21:

(i) Each Employee Benefit Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with all applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Employee Benefit Plan and applicable Legal Requirements;

(ii) Neither Seller nor any ERISA Affiliate has any material liability under any Employee Benefit Plan for which Buyer has or will have any liability (other than liability for any regular annual contributions required under such Employee Benefit Plans), contingent or otherwise, under Titles I or IV of ERISA or the Code, including, without limitation, any liability with respect to any "multiemployer plan" (as defined in ERISA Sections 3(37)(A) or Section 4001(a)(3) or Code Section 414(f) ("**Multiemployer Plan**"), multiple employer plan (as described in Code Section 413(c)), or "single-employer plan" (as defined in ERISA Section 4001(a)(15)), whether or not terminated; self-insured or self-funded "multiple employer welfare arrangement" as such term is defined in ERISA Section 3(40); prohibited transaction (pursuant to Code Section 4975 or ERISA Section 406) with any Employee Benefit Plan that is not subject to an exemption under Code Section 4975 or ERISA Section 408 or the regulations

thereto; excise tax or penalty imposed under ERISA or the Code with respect to any Employee Benefit Plan; or breach of any responsibilities or obligations imposed upon fiduciaries by Title I of ERISA with respect to any Employee Benefit Plan.

(iii) Each Employee Benefit Plan that is an "employee pension benefit plan" as defined in ERISA Section 3(2) other than a Multiemployer Plan and each related trust agreement, annuity contract, or other funding instrument is and has been since its inception intended to be qualified and tax-exempt under the provisions of Code Sections 401(a) and 501(a), or, if applicable, Code Section 403(b), and, for each such Employee Benefit Plan that is not stated on a master and prototype and/or volume submitter plan on which reliance is and can be based on a favorable opinion or advisory letter without the adopting employer having requested an individual determination letter, has been determined by the IRS pursuant to an individual favorable determination letter to be so qualified and tax-exempt or an application for such determination has been made and is currently pending; has not participated in any voluntary compliance or self-correction programs established by the IRS (or the DOL with respect to any fiduciary issues), or entered into a closing agreement with the IRS with respect to the form or operation of any Employee Benefit Plan within the six (6) years preceding the Closing Date; does not have and during the six (6) years preceding the Closing Date has not had any "unfunded accrued liability," as such term is defined under ERISA Section 3(30); has not experienced any "reportable events," as such term is defined under ERISA Section 4043, for which a waiver has not been granted; has not had any "accumulated funding deficiencies," as such term is defined under ERISA Section 302(a)(2) (prior to amendment by P.L. 109-280) or Code Sections 412(a) or 4971 (whether or not waived), nor for years after amendment by P.L. 109-280 any "funding shortfalls" as defined in Code Section 430(c); does not have any liabilities required to be disclosed on any annual report (Form 5500 series) that have not been disclosed; and has not been terminated.

(iv) With respect to each Employee Benefit Plan that is not an "employee pension benefit plan," as defined in ERISA Section 3(2), such plan may be terminated at the time of Closing according to its terms without any prior notice; no commitments have been made to provide lifetime or retiree benefits under any such plan; and no persons have any vested rights under any such plan.

(v) Each Employee Benefit Plan that is a "group health plan," as defined in ERISA Section 607(1) or Code Section 5000(b)(1), and that is maintained by Seller or any ERISA Affiliate has been operated at all times during the six (6) years preceding the Closing Date in material compliance with ERISA, to the extent applicable, the Code, the Social Security Act, and HIPAA.

(vi) All required contributions to all Employee Benefit Plans and all premiums, fees, or other payments required to be made by Seller or any ERISA Affiliate in connection with any Employee Benefit Plan have either been timely made or are reflected in the financial statements on an accrual basis. All returns,

reports, and disclosure statements required to be made under the Code, ERISA, to the extent applicable, or other applicable law with respect to the Employee Benefit Plans other than a Multiemployer Plan have been timely filed or delivered.

(vii) No Employee Benefit Plan is currently or has been within the last three (3) years under audit, inquiry, or investigation by the IRS, DOL, or PBGC, and there are no outstanding issues with reference to such Employee Benefit Plans pending before any governmental agency. Other than routine claims for benefits, there are no actions, mediations, audits, arbitrations, suits, claims, or investigations pending, or to the Knowledge of Seller or any ERISA Affiliate, threatened against or with respect to any of the Employee Benefit Plans sponsored by Seller or any ERISA Affiliate or their assets, and there are no threatened or pending claims by or on behalf of such Employee Benefit Plans or by any employee of Seller or any ERISA Affiliate 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 either Seller, any ERISA Affiliate or such Employee Benefit Plans under any law, nor is there any basis for such a claim.

(viii) Seller and its Wholly Owned Subsidiaries do not have any contracts, agreements, plans, or arrangements under which the contemplated transaction will result in any (i) payments (whether of separation pay or otherwise) becoming due from Seller or any ERISA Affiliate to any current or former employee, director, or consultant, or (ii) vesting, acceleration of payment, or increase in the amount of any benefit payable to or in respect of any such current or former employee, director, or consultant of Seller or any ERISA Affiliate that will, in turn, result in any liability to Buyer.

3.22. Proceedings and Legal Claims. Seller has delivered to Buyer an accurate list and summary description (Schedule 3.22) of all pending or, to the Knowledge of Seller, threatened Proceedings and legal claims with respect to the Seller, each Wholly Owned Subsidiary, the Hospital Businesses, and the Assets. Neither Seller nor any Wholly Owned Subsidiary is in default under any order of any Governmental Authority wherever located. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.22 or as set forth on Schedule 3.22, there are no claims, Proceedings, or investigations pending or, to the Knowledge of Seller, threatened against the Seller, any Wholly Owned Subsidiary, the Hospital Businesses or the Assets, at law or in equity, or before or by any Governmental Authority wherever located. With respect to insured claims, no carrier has issued a "reservation of rights" letter or otherwise denied its obligation to insure and defend Seller, or any of its Wholly Owned Subsidiaries, against covered losses arising therefrom.

3.23. Taxes.

(a) Seller and its Wholly Owned Subsidiaries have filed on a timely basis, or validly extended the time for filing, all federal, state, and local Tax Returns. All Tax Returns are true and correct in all material respects and accurately reflect in all material respects the Tax liabilities of Seller and its Wholly Owned Subsidiaries. All

amounts shown due on the Tax Returns have been or will be paid on a timely basis (including any interest or penalties and amounts due state unemployment authorities) to the appropriate tax authorities.

(b) Seller and its Wholly Owned Subsidiaries, as applicable, have withheld all proper amounts from the compensation of its employees in compliance with all withholding and similar provisions of the Code, including employee withholding and social security taxes, and any and all other applicable laws. All such amounts have been duly and validly remitted to the proper taxing authority. Further, Seller and its Wholly Owned Subsidiaries have withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by them to independent contractors, creditors and other Persons for which withholding or payment is required by applicable Legal Requirements.

(c) No deficiencies for any Taxes relating to the Seller or its Wholly Owned Subsidiaries have been asserted or, to the Knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the Knowledge of Seller, threatened. There are no outstanding agreements by Seller or its Wholly Owned Subsidiaries for the extension of time for the assessment of any Taxes. Seller and its Wholly Owned Subsidiaries have not taken any action in respect of any Taxes that may have a material adverse effect upon the Hospital Businesses or the Assets as of or subsequent to Closing.

(d) To Seller's knowledge, no Government Authority intends to assess any additional Taxes for any period for which Tax Returns have been filed. No claim has ever been made by a Government Authority in a jurisdiction where Seller or any Wholly Owned Subsidiary does not file Tax Returns that such entity is or may be subject to Tax in that jurisdiction. Neither Seller nor any of its Wholly Owned Subsidiaries has received written notice of Tax liens on any of the Assets.

(e) Seller is not a party to any Tax allocation or sharing contract. Seller is not, and has not been, a member of any affiliated group within the meaning of Section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law filing a consolidated federal income Tax Return.

(f) Each of Seller and its Wholly Owned Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the IRS and the State of Connecticut regarding such Tax status and nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption.

(g) Neither Seller, nor its Wholly Owned Subsidiaries, has any liability for the Taxes of any other person or entity (other than a subsidiary under IRS regulation 1.1502-6), as a transferee or successor, by contract or otherwise.

3.24. Medical Staff; Physician Relations. Seller has provided to Buyer true, correct, and complete copies of the bylaws and rules and regulations of the medical staff of the Hospital,

as well as a list of all current members of the medical staff. Except as set forth in Schedule 3.24, there are no adverse actions with respect to any medical staff members of the Hospital or any applicant thereto for which a medical staff member or applicant has requested a judicial review hearing that has not been scheduled or has been scheduled but has not been completed, and there are no pending or, to the Knowledge of Seller, threatened disputes with applicants, staff members, or health professional affiliates, and Seller knows of no basis therefor, and all appeal periods in respect of any medical staff member or applicant against whom an adverse action has been taken have expired. No member of the medical staff of the Hospital has been excluded from participation in any Government Payment Program.

3.25. Restricted Assets. Except as set forth on Schedule 3.25 hereto, neither Seller, its Wholly Owned Subsidiaries nor any of their predecessors has received any loans, grants, or loan guarantees pursuant to the Hill-Burton Act program, the Health Professions Educational Assistance Act, the Nurse Training Act, the National Health Planning and Resources Development Act, and the Community Mental Health Centers Act, as amended, or similar laws or acts relating to health care facilities. The transactions contemplated hereby will not result in any obligation on Buyer or any of its Affiliates to repay any of such loans, grants, or loan guarantees, nor subject Buyer, its Affiliates, or the Assets to any lien, restriction, or obligation, including any requirement to provide uncompensated care.

3.26. Brokers and Finders. Except for Cain Brothers, which is representing Seller, neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.27. Payments. None of the Hospital Businesses has, to Seller's Knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Neither Seller nor any of its Wholly Owned Subsidiaries has, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor any of its Wholly Owned Subsidiaries, nor to Seller's Knowledge, any officer, director or trustee of Seller or any Wholly Owned Subsidiary has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom Seller or any Wholly Owned Subsidiary conducts or has conducted any of the Hospital Businesses.

3.28. Joint Ventures.

(a) Schedule 3.28 sets forth for each Joint Venture, [and as of the Closing Date, also for each Converted Venture]: (i) its name and jurisdiction of incorporation or organization; (ii) the number of authorized shares of each class of its capital stock or other equity or non-equity interests; (iii) the number of issued and outstanding shares of each class of its capital stock or other equity or non-equity interests, the names of the holders thereof, and the number of shares or other equity or non-equity interests held by each such holder; (iv) the number of shares of its capital stock or

other equity interests held in treasury; and (v) its directors and officers, general partners, or managers, as the case may be. Seller does not hold any equity interest in any entity other than its Wholly Owned Subsidiaries and the Joint Ventures[, and as of the Closing Date, the Converted Ventures].

(b) Subject to Section 5.19, each Joint Venture: (i) if it is a for profit or nonprofit corporation, is duly incorporated and validly existing under the laws of the state of its incorporation and is duly qualified and in good standing as a foreign corporation in the jurisdiction of its principal place of business if not incorporated therein; (ii) if it is a limited liability company, is duly organized, validly existing, and, if applicable, in good standing under the laws of the state of its organization and is duly qualified and, if applicable, in good standing as a foreign limited liability company in the jurisdiction of its principal place of business if not organized therein; and (iii) if it is a partnership, trust, or other entity, is duly formed, validly existing, and, if applicable, in good standing in the jurisdiction of its principal place of business if not formed therein. To the Knowledge of Seller, each Joint Venture, [and as of the Closing Date, each Converted Venture,] has full corporate, limited liability company, partnership, trust, or other applicable power and authority and all licenses and permits (including authorizations to do business in any applicable state) necessary to carry on the businesses in which it is engaged and in which it presently proposes to engage, and to own and use the properties owned and used by it. To the Knowledge of Seller, each Joint Venture, [and as of the Closing Date, each Converted Venture,] has not materially violated any Legal Requirement or material Contract or agreement.

(c) Seller has delivered to Buyer accurate and complete copies, as applicable, of the articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholder or membership agreement, as amended to date and in its possession, of each Joint Venture[, and as of the Closing date, of each Converted Venture]. Except as set forth on Schedule 3.28 hereto, all of the issued and outstanding shares of capital stock or other equity or non-equity interests of each Joint Venture, and as of the Closing Date, of each Converted Venture, that have been issued to Seller (or any Wholly Owned Subsidiary thereof) have been duly authorized and are validly issued, fully paid, and nonassessable. To the Knowledge of Seller, none of the Joint Ventures, [and as of the Closing Date,] none of the Converted Ventures, is in default under or in violation of any provision of its articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholders or membership agreement.

(d) Except as set forth in Schedule 3.28, to the Knowledge of Seller, (i) there is no outstanding subscription, option, convertible or exchangeable security, preemptive right, warrant, call, or agreement (other than this Agreement) relating to the stock or other equity or non-equity interests of the Joint Ventures, [and as of the Closing Date, the Converted Ventures], or other obligation or commitment of any Joint Venture, [and as of the Closing Date, of any Converted Ventures], to issue any shares of capital stock or other equity interests; and (ii) there are no voting trusts or other agreements, arrangements, or understandings applicable to the exercise of voting or any other rights with respect to any shares of Joint Venture stock or other equity or

non-equity interests[, and as of the Closing Date, to any shares of Converted Venture stock or other equity or non-equity interests]. Seller (or any Wholly Owned Subsidiary thereof) has good, marketable, and indefeasible title to all shares of the stock or other equity or non-equity interests of the Joint Ventures, [and as of the Closing Date, of the Converted Ventures,] set forth in Schedule 3.28 and, except as set forth on Schedule 3.28, has the absolute right to sell, assign, transfer, and deliver the same to the Buyer, free and clear of all claims, security interests, liens, pledges, charges, escrows, options, proxies, rights of first refusal, preemptive rights, mortgages, hypothecations, prior assignments, title retention agreements, indentures, security agreements, or any other limitation, encumbrance, or restriction of any kind.

(e) Except as set forth in Schedule 3.28, to the Knowledge of Seller, the Joint Ventures, [and as of the Closing Date, the Converted Ventures,] do not control, directly or indirectly, or have any direct or indirect equity participation in any corporation, limited liability company, partnership, trust, or other business association.

3.29. Quality and Condition of Assets. The Assets and the Excluded Assets constitute all assets that are held or used by Seller or its Wholly Owned Subsidiaries for the conduct of the Hospital Businesses in the manner conducted as of the date of this Agreement. Except as set forth in Schedule 3.29, to the Knowledge of Seller, all buildings, structures, facilities, and Material Tangible Assets included in the Assets are free from material defects and are usable in the regular and ordinary course of business, and conform in all material respects to all applicable Legal Requirements relating to their use and operation by Seller or its Wholly Owned Subsidiaries.

3.30. Experimental Procedures. Seller (or any Wholly Owned Subsidiary thereof) has not performed or permitted the performance of any experimental or research procedures or studies involving patients of the Hospital Businesses not authorized and conducted in accordance with the procedures of the Institutional Review Board of the Hospital.

3.31. Full Disclosures. This Agreement, the Schedules hereto, and all Closing Documents furnished and to be furnished to Buyer and their representatives by Seller pursuant hereto, when taken in their entirety, do not and will not include any untrue statement of a material fact. Copies of all documents referred to in any Schedule hereto in the possession of Seller have been delivered or made available to Buyer and its representatives and constitute true, correct, and complete copies thereof and include all amendments, exhibits, schedules, appendices, supplements, or modifications thereto or waivers thereunder.

4. REPRESENTATIONS OF BUYER

Buyer makes the following representations to Seller on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization.

(a) Buyer is a corporation duly organized and validly existing and in good standing under the laws of Connecticut. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease

and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. Buyer has made available to Seller a true and complete copy of its organizational documents.

(b) PMH is a corporation duly organized and validly existing and in good standing under the laws of Delaware. PMH has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing.

4.02. Power and Authority; Due Authorization.

(a) Buyer has full power and authority to (i) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (ii) perform its obligations under this Agreement and such Closing Documents and (iii) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary corporate action.

(b) PMH has full power and authority to (i) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (ii) perform its obligations under this Agreement and such Closing Documents and (iii) consummate the transactions contemplated by this Agreement. The execution and delivery by PMH of this Agreement and the Closing Documents to which it is or becomes a party, the performance by PMH of its obligations under this Agreement and such Closing Documents, and the consummation by PMH of the transactions contemplated by this Agreement have been duly authorized on behalf of PMH by all necessary corporate action.

4.03. Consents; Absence of Conflicts, Etc.

(a) The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(i) are within its corporate powers, are not in contravention of its certificate of incorporation, shareholders agreement, and bylaws and have been approved by all required corporate action;

(ii) do not violate any Legal Requirement to which it is subject;

(iii) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound;

(iv) will not violate any statute, law, rule, or regulation of any governmental authority to which it may be subject; and

(v) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which it may be subject.

(b) The execution, delivery and performance by PMH of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(i) are within its corporate powers, are not in contravention of its certificate of incorporation, shareholders agreement, and bylaws and have been approved by all required corporate action;

(ii) do not violate any Legal Requirement to which it is subject;

(iii) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound;

(iv) will not violate any statute, law, rule, or regulation of any governmental authority to which it may be subject; and

(v) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which it may be subject.

4.04. Due Execution; Binding Agreement. This Agreement has been duly and validly executed and delivered by Buyer. Each Closing Document to which Buyer will be a party will be duly and validly executed and delivered by Buyer at the Closing. This Agreement constitutes, and each of the Closing Documents to which Buyer will be a party will constitute (upon execution and delivery thereof by Buyer at the Closing), the valid and legally binding obligations of Buyer, enforceable against it in accordance with the terms hereof and thereof.

4.05. Proceedings. There are no claims, Proceedings, or investigations pending or, to Buyer's knowledge, threatened that: (a) adversely affect or seek to prohibit, restrain, or enjoin the execution and delivery of this Agreement, (b) adversely affect or question the validity or enforceability of this Agreement, (c) question the power or authority of Buyer to carry out the transactions contemplated by, or to perform its obligations under, this Agreement, or (d) would result in any change that would adversely affect in any material respect the ability of Buyer to perform any of its obligations hereunder.

4.06. Availability of Funds. Buyer will have and will apply at the time of Closing sufficient cash or other immediately available funds necessary to enable Buyer to consummate the transactions contemplated hereby in accordance with the terms hereof.

5. PRE-CLOSING COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by Buyer, Seller will, and will require its Affiliates and Wholly Owned Subsidiaries to:

(a) carry on its business pertaining to the Hospital Businesses in substantially the same manner as presently conducted and not make any material change in personnel, operations, finance, accounting policies, or real or personal property pertaining to the Hospital Businesses;

(b) maintain the Hospital Businesses and all parts thereof in good operating condition, ordinary wear and tear excepted;

(c) perform all of its material obligations under agreements relating to or affecting the Hospital Businesses or the Assets;

(d) comply in all material respects with all applicable laws and other Legal Requirements;

(e) keep in full force and effect present insurance policies or other comparable insurance pertaining to the Hospital Businesses; and

(f) use its commercially reasonable efforts to maintain and preserve its business organizations intact, retain its present employees of the Hospital Business, and maintain its relationships with physicians, suppliers, customers, and others having business relations with the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to by Buyer in writing, Seller will not, and will not permit any Affiliate or Wholly Owned Subsidiary to:

(a) amend or terminate any of the Assumed Contracts, enter into any Contract or commitment, or incur or agree to incur any liability, except as provided herein or in the ordinary course of business and in no event greater than Seventy-Five Thousand Dollars ($75,000) per item;

(b) enter into any Contract or commitment with physicians or other referral sources;

(c) increase compensation payable or to become payable or make any bonus payment to or otherwise enter into one or more bonus agreements with any employee of the Hospital Businesses, except increases in compensation or bonus payments or agreements that are otherwise made in the ordinary course of business consistent with past practices and in accordance with existing personnel policies;

(d) create, assume, or permit to exist any new debt, mortgage, pledge, or other lien or encumbrance upon any of the Assets in an amount in excess of Seventy-Five Thousand Dollars ($75,000) whether now owned or after acquired;

(e) acquire (whether by purchase or lease) or sell, assign, lease, or otherwise transfer or dispose of any property (including Real Property), plant, or equipment having a net book value in excess of Seventy-Five Thousand Dollars ($75,000), except in the ordinary course of business;

(f) purchase capital assets other than in accordance with the approved capital budget of Seller previously provided to Buyer;

(g) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided;

(h) hire or terminate the employment of any employee of the Hospital Businesses at the level of manager or higher (including, without limitation, any officer of the Hospital Businesses);

(i) sell or factor any Accounts Receivable;

(j) cancel, forgive, release, discharge or waive any Person's obligation to pay or to perform obligations in respect of any Assets, or agree to do any of the foregoing, except in the ordinary course of the business of the Hospital Businesses consistent with past practices;

(k) change any accounting method, policy or practice or reduce any reserves in the Financial Statements, except (i) reductions in reserves pertaining to Government Payment Programs or third party payors made in the ordinary course of business consistent with past practices and (ii) changes required by changes in GAAP or applicable Legal Requirements;

(l) terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for amendments required to comply with this Agreement or applicable Legal Requirements;

(m) amend or agree to amend the governing documents of any Joint Venture, except (x) immaterial amendments or amendments required to comply with applicable Legal Requirements or to assign and transfer to Buyer the Seller's ownership interest in, or for Buyer to become a partner or member of, the Joint Venture, or (y) as contemplated by Section 5.19 hereof; or

(n) take any action outside the ordinary course of business of the Hospital Businesses or their related ancillary services.

5.03. Employee Matters.

(a) As of the Closing Date, Seller shall terminate all of its employees at the Hospital Businesses, and Buyer shall offer employment to all active employees in good standing as of the Closing Date who satisfy customary pre-employment screening procedures, in positions similar to those then being provided by Seller. Nothing herein shall be deemed to affect or limit in any way normal management prerogatives of Buyer with respect to employees or to create or grant to any such employees third party beneficiary rights or claims of any kind or nature. In respect of the employees employed by Buyer as of the Closing Date, and except as limited by the terms of applicable collective bargaining agreements, Buyer shall provide such employees with regionally competitive wages and employee benefits comparable to the wages and benefits generally offered to employees of other hospitals owned and operated by Buyers as of the Closing Date and shall honor prior length of service for purposes of determining eligibility and vesting in its benefit plans; *provided, however*, that no such prior service credit need be given in respect of any new plan commenced or participated in by Buyer and generally applicable to other hospitals owned and operated by Buyer in which no prior service credit is given to or recognized for other plan beneficiaries. In extending such benefits, Buyer shall give such employees credit for the satisfaction of pre-existing condition limitations in its welfare benefit plans to the same extent that such employees have satisfied such limitations under the current welfare benefit plans of Seller. Notwithstanding anything to the contrary contained in this Section 5.03, Buyer shall not have any obligation to offer employment to, or continue to employ, any employee (x) at the Hospital Businesses who has been excluded from participation in federal health care programs, or (y) whose name is not set forth on the Employee Lists.

(b) Not later than fifteen (15) days prior to the Closing, Seller shall deliver to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Wholly Owned Subsidiaries (indicating in the list whether each employee is classified as exempt or nonexempt by Seller or such Wholly Owned Subsidiary), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Wholly Owned Subsidiaries (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor) (collectively, the "**Employee Lists**").

5.04. Access to and Provision of Additional Information.

(a) Seller shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Buyer full and complete access to and the right to inspect the plants, properties, books, and records of the Hospital Businesses, and will furnish Buyer with such additional

financial and operating data and other information as to the business and properties of Seller pertaining to the Hospital Businesses as Buyer may from time to time reasonably request without regard to where such information may be located. Buyer's right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Hospital Businesses and the delivery of patient care. Buyer agrees that no inspections shall take place and no employees or other personnel of the Hospital Businesses shall be contacted by Buyer without Buyer's first providing reasonable notice to Seller and coordinating such inspection or contact with Seller.

(b) Within two (2) business days after they are created (but in any event no later than fifteen (15) days following the end of each calendar month prior to Closing), Seller shall deliver or cause to be delivered to Buyer true and complete copies of the management prepared unaudited balance sheets and the related unaudited statements of income of, or relating to, Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses for each month then ended, which presentation shall be true, correct, and complete in all material respects, shall have been prepared from and in accordance with the books and records of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses, and shall fairly present the financial position and results of operations of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such financial statements need not include required footnote disclosures. To the extent permitted by law, Seller shall notify Buyer in writing and shall keep Buyer informed of any unexpected emergency or other materially adverse unanticipated change in the business of any of the Hospital Businesses and of any governmental complaints, investigations, or adjudicatory proceedings (or governmental communications indicating that the same may be contemplated) or of any other such matter.

(c) Until the Closing Date, to the extent permitted by law, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, grievances, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any individually identifiable health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with HIPAA and with any other Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this Section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Governmental Approvals.

(a) Seller's Obligations.

(i) Seller shall (a) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Seller to perform its obligations under this Agreement (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein); and (b) assist and cooperate with Buyer and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Buyer deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein).

(ii) Seller shall, if and to the extent required by Legal Requirements, file all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Seller agrees to furnish to Buyer such information concerning Seller as Buyer needs to perform its obligations under Section 5.05(b)(ii) of this Agreement.

(b) Buyer's Obligations.

(i) Buyer shall (a) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Buyer to perform its obligations under this Agreement (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein), and (b) assist and cooperate

with Seller and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Seller deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein). Buyer shall pay all of the costs of any fees due in respect of filings made to the Attorney General and Commissioner of Public Health of the State of Connecticut, including, without limitation, fees required to be paid by Buyer pursuant to CT Gen Stat § 19a-486c(c) and CT Gen Stat § 19a-486d(a) shall remain the obligation of Buyer.

(ii) Buyer shall, if and to the extent required by Legal Requirements, file or cause to be filed all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Buyer agrees to furnish to Seller such information concerning Buyer as Seller needs to perform its obligations under Section 5.05(a)(ii) of this Agreement. Buyer shall pay the costs of any fees due in respect of filings required by the HSR Act.

5.06. Connecticut Transfer Act. Certain components of the Real Property (including the Hospital) may constitute, in whole or in part, "Establishments" as the term is defined in the Transfer Act (collectively, the "**Establishment Real Properties**"). Accordingly, Seller and Buyer shall prepare an appropriate Transfer Act Form and accompanying Environmental Condition Assessment ("**ECAF**") for each Establishment Real Property to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Seller shall execute as transferor and Buyer shall execute as transferee and Certifying Party (as all such terms are defined in the Transfer Act). Within ten (10) days after the Closing Date, Buyer shall (i) file the fully executed Transfer Act Form and ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEEP**"); (ii) pay the initial filing fee and any and all subsequent Transfer Act fees (which shall be reimbursed by Seller); and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). In order to evaluate the potential scope and cost of Transfer Act obligations that may be required, prior to the Closing, Buyer shall have the right to perform limited Phase II assessments with respect to the Real Property. Buyer or its designee shall conduct and complete, at Buyer's sole expense, any actions required (as determined by Buyer in its reasonable discretion) as a result of the filing of the Transfer Act Form and the ECAF, to comply with the Transfer Act, and, if appropriate, to obtain written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" that the Hospital Businesses have been remediated in full compliance with the Connecticut Remediation Standard Regulations (collectively "**Transfer**

Act Activities"). Buyer shall complete all Transfer Act Activities as soon as practicable, but in any event within any deadline defined by or pursuant to the Transfer Act (as the same may be extended). Notwithstanding the foregoing **[need to have an approval process to review costs]**[10], Seller shall pay Buyer for all costs and expenses that Buyer incurs in connection with Transfer Act Activities. Seller and Buyer agree to execute and deliver all documents reasonably requested by the other to comply with the Transfer Act. All undefined terms in this Section 5.06 shall have the meanings set forth in the Transfer Act. Notwithstanding anything to the contrary in this Agreement, the parties agree that any and all fees, expenses and other costs to be paid by Seller under this Section 5.06 shall be paid first from funds held as part of the indemnity reserve established pursuant to Section 10.09.

5.07. No-Shop Clause. Seller agrees that, from and after the date of the execution and delivery of this Agreement by Seller until the termination of this Agreement, neither Seller, nor any Affiliate of Seller will, without the prior written consent of Buyer: (i) offer for sale the Assets (or substantially all of the Assets) or any ownership interest in any entity owning any of the Assets, (ii) solicit offers to buy all or substantially all of the Assets or any ownership interest in any entity owning any of the Assets, (iii) hold discussions with any party (other than Buyer) looking toward such an offer or solicitation or looking toward a merger, consolidation, joint venture, or similar transaction involving any entity owning any of the Assets, or (iv) enter into any agreement with any party (other than Buyer) with respect to the sale or other disposition of the Assets (or substantially all of the Assets) or any ownership interests in any entity owning any of the Assets or with respect to any merger, consolidation, joint venture, or similar transaction involving any entity owning any of the Assets. Seller will promptly communicate to Buyer the substance of any inquiry or proposal concerning any such transaction.

5.08. Casualty. If, on or before the Closing Date, any of the Real Property used by the Hospital Businesses is destroyed or damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Real Property, in the aggregate, is rendered unsuitable for their primary intended use for at least six (6) months, Buyer may elect, by giving written notice to Seller within ten (10) business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this Agreement in accordance with Section 9.04(a)(v), (ii) consummate the transaction in spite of such destruction or damage, but reduce the Purchase Price by the fair market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds (or the right to receive the insurance proceeds) payable on account of such destruction or damage, plus any deductibles or copayments required under the applicable insurance policy in respect of such claim. In the absence of an agreement among the parties regarding the amount of any Purchase Price reduction for purposes of clause (ii) above (if applicable), an MAI appraiser mutually selected by the parties and paid equally by Seller, on the one hand, and Buyer, on the other hand, will determine any reduction in Purchase Price pursuant to such clause (ii).

[10] Subject to review

5.09. Consents to Assignment.

(a) Seller shall (or shall cause its Wholly Owned Subsidiaries to) promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing, provided that Seller and its Wholly Owned Subsidiaries shall not be required to make any payments or economic concessions to landlords or other counterparties to obtain such consents.

(b) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a contract that supersedes or replaces an existing Contract between Seller (or its Wholly Owned Subsidiary) and a third party. Such new contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller (or its Wholly Owned Subsidiary) that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller (or its Wholly Owned Subsidiary) that are Excluded Liabilities. If Buyer enters into a replacement contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 10), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement contract did not exist or such assumption of Excluded Liabilities was not required.

5.10. Insurance Ratings. Seller will take all action reasonably requested by Buyer to enable Buyer to succeed to the workers' compensation and unemployment insurance ratings, and other ratings for insurance or other purposes established by Seller or its Affiliates for the Hospital Businesses. Buyer shall not be obligated to succeed to any such ratings, except as Buyer may elect to do so.

5.11. Efforts to Close.

(a) Seller shall use its commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Seller shall notify Buyer as soon as practicable of any event or matter that comes to its attention that may reasonably be expected to prevent or materially delay the conditions to the obligations of Seller being met.

(b) Buyer shall use its commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Buyer shall notify Seller as soon as practicable of any event or

matter that comes to the attention of Buyer that may reasonably be expected to prevent or materially delay the conditions to Buyer's obligations being met.

5.12. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets, other than the Permitted Encumbrances, to be released and discharged at or before Closing.

5.13. [Intentionally Omitted.]

5.14. Medical Staff Disclosure. Seller shall deliver to Buyer a confidential written disclosure containing a brief description of all adverse actions taken against medical staff members or applicants in the past three (3) years that, to the Knowledge of Seller, could result in claims or actions against Seller, its Wholly Owned Subsidiaries or the Hospital Businesses and that are not disclosed in the minutes of the meetings of the Medical Executive Committee of the medical staff of the Hospital Businesses, **[which have been provided to Buyer.]**[11]

5.15. Satisfaction of Bond Obligations. At its sole cost and expense, Seller shall do all things necessary, desirable, and appropriate to cause the complete and valid payment or, if necessary, defeasance of its obligations under that certain Loan Agreement and Security Agreement dated as of December 1, 2010 by and between Seller, the Hospital, RBS Citizens, National Association, and the State of Connecticut Health and Educational Facilities Authority (the "**Loan Agreement**"), which secures the State of Connecticut Health and Educational Facilities Authority Revenue Bonds, Waterbury Hospital Issue, Series D, such that all liens and mortgages secured by the Loan Agreement shall be released at the time of the Closing.

5.16. New and Existing Collective Bargaining Agreement. **[Pending discussion with Labor counsel]**

(a) Seller is currently party to three collective bargaining agreements:

(i) The "Nurses CBA" is between the Seller and Connecticut Health Care Associates and covers registered nurses and licensed practical nurses with effective dates from October 1, 2013 through September 30, 2017. Neither the Buyer nor the Seller expect that the Nurses CBA shall be renegotiated prior to the Closing. The Seller shall not enter into any modification of the Nurses CBA prior to the Closing without the express written consent of the Buyer. The Buyer shall accept the terms of the Nurses CBA, as adjusted with regard to pension benefits and hire bargaining unit employees as set forth in the Letter of Agreement on Successorship contained in the Nurses CBA. The Buyer shall provide the Union a written notice of such acceptance at least thirty (30) days prior to the Closing in accordance with said Letter of Agreement on Successorship.

(ii) The "Technical Unit CBA" is between the Seller and Connecticut Health Care Associates and covers technical employees with effective dates from December 9, 2015 through September 30, 2018. Neither the Buyer nor the Seller expect that the Technical Unit CBA shall be renegotiated prior to the Closing.

[11] Subject to due diligence

The Seller shall not enter into any modification of the Technical Unit CBA prior to the Closing without the express written consent of the Buyer. The Buyer shall accept the terms of the Technical Unit CBA and hire bargaining unit employees as set forth in the Letter of Agreement on Successorship contained in the Technical Unit CBA. The Buyer shall provide the Union a written notice of such acceptance at least thirty (30) days prior to the Closing in accordance with said Letter of Agreement on Successorship.

(iii) The "Service & Maintenance CBA" is between the Seller and New England Health Care Employees Union, District 1199 with effective dates from March 6, 2013 through February 29, 2016. Negotiations for a successor collective bargaining agreement to the Service & Maintenance CBA may commence prior to the Closing. The Seller shall keep Buyer apprised of, and consult with Buyer regarding, the status of negotiations for a successor collective bargaining agreement to the Service & Maintenance CBA. Seller shall not, without the Buyer's written consent, enter into any new or successor collective bargaining agreement to the Service & Maintenance CBA or extension thereof that contains additional costs and/or terms that differ from the terms of the current Service & Maintenance CBA in a manner that the Buyer reasonably believes will impact Buyer's ability to operate the Hospital after the Closing. Buyer shall not interfere with Seller's bargaining obligations under the National Labor Relations Act. If the purchase becomes effective during the life of the existing Service & Maintenance CBA (including any extensions required thereof by its terms), the Buyer shall accept the terms of that agreement by written notice, to be provided at least thirty (30) days prior to the Closing.

(b) If, prior to the Closing, any bargaining obligations arise to the Seller to a bargaining unit not covered by any of the three existing collective bargaining agreements, Seller shall immediately notify Buyer. The Seller shall keep Buyer apprised of, and consult with Buyer regarding, the status of negotiations for a collective bargaining agreement for any such additional bargaining unit. Seller shall not, without the Buyer's written consent, enter into any collective bargaining agreement covering any such unit that contains terms that the Buyer reasonably believes will impact Buyer's ability to operate the Hospital after the Closing. Buyer shall not interfere with Seller's bargaining obligations under the National Labor Relations Act.

5.17. Title Commitment. Buyer shall obtain a current title commitment (the "**Title Commitment**") issued by [Land Services USA] (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein. The Title Commitment shall set forth the state of title to the Owned Real Property, together with all exceptions or conditions to such title, including, without limitation, all easements, restrictions, rights-of-way, covenants, reservations, and all other encumbrances affecting the Owned Real Property that would appear in an owner's title policy, if issued. The Title Commitment shall contain the express commitment of the Title Company to issue an Owner's Title Policy (the "**Title Policy**") to Buyer in an amount equal to the amount being allocated by the parties to the Owned Real Property insuring good and marketable title to the Owned Real Property subject only to the Permitted Encumbrances with the standard printed exceptions endorsed or deleted as agreed by Buyer.

5.18. Surveys. Seller shall deliver copies of all existing surveys of the Real Property, in its possession, to Buyer. Buyer may obtain, at its sole cost and expense, current as-built surveys of the Real Property (the "**Surveys**"). The Surveys shall meet the requirements of an ALTA/ASCM survey and otherwise be in form and detail satisfactory to Buyer. Unless otherwise agreed by Buyer, the Surveys shall (i) be currently dated; (ii) show the location on the Real Property of all improvements, fences, evidences of abandoned fences, lakes, ponds, creeks, streams, rivers, easements, roads, and rights-of-way; (iii) identify all easements and rights-of-way by reference to the recording information applicable to the documents creating such easements or rights-of-way; (iv) show any encroachments onto the Real Property from any adjacent property, any encroachments from the Real Property onto adjacent property, and any encroachments into any easement or restricted area within the Real Property; (v) locate all existing improvements (such as buildings, power lines, fences, and the like); (vi) locate all dedicated public streets or other roadways providing access to the Real Property, including all curb cuts and all alleys; (vii) locate all set-back lines and similar restrictions covering the Real Property or any part thereof and any violations of such restrictions; and (viii) show thereon a legal description of the boundaries of the Real Property by metes and bounds or other appropriate legal description. Each Survey shall contain the surveyor's certification to Buyer, Seller, and the Title Company that (i) the Survey was made on the ground; (ii) there are no visible or recorded easements, discrepancies, conflicts, encroachments, or overlapping of improvements except as shown on the Survey; (iii) the Survey correctly shows all visible or recorded easements or rights of way across the Real Property or any other easements or rights of way of which the surveyor has been advised, including, without limitation, those matters affecting title reflected in the Title Commitment; (iv) the Survey correctly shows the location of all buildings, structures, and other improvements situated on the Real Property; (v) the Survey conforms to all applicable minimum guidelines for surveys of comparable property as set forth in applicable laws, regulations, or professional standards; (vi) all streets abutting the Real Property and all means of ingress to and egress from the Real Property have been completed, dedicated, and accepted for public maintenance by the relevant municipal body; (vii) except as shown thereon, the Real Property is not located within the 100 year flood plain or other flood hazard area; (viii) the Survey is a true, correct, and accurate representation of the Real Property; and (ix) such other matters as may be required by the Title Company to allow it to issue the Title Policy.

5.19. [Conversion of Non-Profit JVs. Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its respective representatives and counsel to cooperate with, the other party to take all necessary, proper or advisable actions to consummate the conversion of each of the Non-Profit JVs into for-profit entities. Upon the consummation of each such conversion, the new for-profit entity shall be referred to herein as a "**Converted Venture**."]

6. ADDITIONAL COVENANTS

6.01. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment

Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five (5) years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies maintained by such party. In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense, any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to cooperate with, the other party after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this Section shall not unreasonably interfere with the conduct of business of the other party and nothing in this Section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) Buyer agrees to abide by all applicable laws relating to the confidential information it acquires. Buyer agrees to maintain the patient records delivered to Buyer at the Closing at the Hospital Businesses after Closing in accordance with applicable Legal Requirements (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. §1395(v)(l)(i)), the privacy and security requirements of HIPAA, including, but not limited to, the Administrative Simplification subtitle of HIPAA, and applicable state requirements with respect to medical privacy and security and requirements of relevant insurance carriers, all in a manner consistent with the maintenance of patient records generated by the Hospital Businesses after the Closing.

6.02. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed 120 days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller and its Wholly Owned Subsidiaries relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior

to the Closing limited powers of attorney (on behalf of itself and its Wholly Owned Subsidiaries, as applicable) substantially in the form of Exhibit B hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall indemnify and hold harmless Seller and its Wholly Owned Subsidiaries, and their officers, trustees and employees for all claims, liabilities and costs arising from or relating to use of such licenses and registration after the Closing Date.

6.03. Noncompetition. Seller hereby covenants that at all times from the Closing Date until the fifth (5th) anniversary of the Closing Date, Seller and its Affiliates shall not, directly or indirectly, except as a member, consultant, or contractor to or of Buyer (or any Affiliate of Buyer), own, lease, manage, operate, control, or participate in any manner with the ownership, leasing, management, operation, or control of any business that offers services in competition with the Hospital Businesses, including but not limited to any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a thirty (30) mile radius of the Hospital (the "**Restricted Area**"), without Buyer's prior written consent (which Buyer may withhold in its sole and absolute discretion); *provided, however*, that (i) Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates through the Hospital: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services provided by Buyer, and (ii) Seller and its Affiliates will not be precluded from participating in activities that are otherwise described in Schedule 6.03 of this Agreement. In the event of a breach of this Section 6.03, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Seller and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section 6.03 form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section 6.03. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

6.04. Allocation of Purchase Price; Cooperation on Tax Matters.

(a) Within a reasonable time after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospital Businesses and the Assets. Such allocation will be in accordance with Section 1060 of the Code. Buyer's proposed allocation will become final and binding on the parties 45 days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within 60 days after Seller gave its objection to Buyer. If a final resolution is not reached within 60 days after Seller has submitted its objection in writing, each of Buyer and Seller shall make their own independent allocation of the total consideration among the Hospital Businesses and the Assets. If Seller and Buyer reach agreement upon the allocation (or Seller does not object to Buyer's proposed allocation), Seller and Buyer will be bound by the agreed allocation and (for federal and state Tax purposes) account for and report the transactions contemplated by this Agreement in accordance with such allocation, and will not voluntarily take any position (whether in Tax Returns, Tax audits or other Proceedings) inconsistent with such allocation. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the IRS in accordance with such allocation.

(b) Following the Closing, the parties shall cooperate fully with each other and shall make available to the other, as reasonably requested and at the expense of the requesting party, and to any taxing authority (to the extent required by Legal Requirements), all information, records, or documents in their possession relating to the Assets, the Hospital Businesses, and the Assumed Liabilities as is reasonably necessary for the preparation and filing of any Tax Return, claim for refund of Taxes, or other filings relating to Taxes, or in connection with any audit or other proceeding instituted by any taxing authority. In the case of any audit, examination, or other proceeding with respect to Taxes for which Seller is or may be liable pursuant to this Agreement, Buyer shall promptly inform Seller, and Buyer shall execute or cause to be executed powers of attorney or other documents necessary to enable Seller to take all actions reasonably deemed necessary by Seller with respect to such audit, examination, or proceeding to the extent such audit, examination, or proceeding may affect the amount of Taxes for which Seller is liable pursuant to this Agreement. Seller shall have the right to control any such audit, examination, or proceeding, and, if there is a reasonable basis therefor, to initiate any claim for refund, file any amended return, or take any other action that it deems appropriate with respect to such Taxes.

6.05. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can execute or cause to be

executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

6.06. Seller's Cost Reports. Seller, at its expense, shall prepare and timely file all terminating and other cost reports required or permitted by law to be filed under the Government Payment Programs or other third party payor programs and the State Health Agency for periods ending on or prior to the Closing Date, or as a result of the consummation of the transactions described herein (the "**Cost Reports**"). Buyer shall provide Seller with access to all records and data necessary for completion of Cost Reports. Buyer shall forward to Seller any and all correspondence relating to Cost Reports within five (5) business days after receipt by Buyer. Buyer shall remit any receipts of funds relating to Cost Reports within ten (10) business days after receipt by Buyer and shall forward to Seller any demand for payments within five (5) business days after receipt by Buyer. Seller shall retain all rights to the Cost Reports including any amounts receivable or payable in respect of such reports or reserves relating to such reports. Such rights shall include the right to appeal any determinations by Government Payment Programs relating to Cost Reports. Seller shall retain the originals of Cost Reports, correspondence, work papers and other documents relating to Cost Reports; *provided, however*, that Seller shall make certain that the Hospital Businesses retain copies of such Cost Reports, correspondence, work papers and other documents in order that they are available to Buyer following the Closing Date.

6.07. Continuation of Hospital and Post-Care Continuum. For a period of at least five (5) years after Closing, Buyer (i) will continue to provide at the Hospital Businesses essential clinical and other services described on Exhibit C, and (ii) will not merge, dissolve, consolidate, sell or otherwise dispose of the Hospital without the consent of Seller or its designee (other than to an Affiliate of Buyer or PMH); *provided, however*, that this clause (ii) shall not prohibit Buyer from entering into or engaging in (x) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or that relates to a broader group of facilities or assets than the Hospital, or (y) any corporate-level transactions involving PMH's assets, stock or securities, including mergers, recapitalizations or reorganizations.

6.08. Sale of Hospital Within Three Years. In the event of a sale of all of the Hospital Businesses for cash, whether by merger, sale, or other transaction, at any time prior to the third (3rd) anniversary of the Closing, for a purchase price in excess of (a) the Purchase Price paid by Buyer for the Assets, *plus* (b) the amount of any expenditures made by Buyer or its Affiliates with respect to the Hospital Businesses and their affiliated businesses in the Greater Waterbury region in such period, *plus* (c) any losses generated by the Hospital Businesses and its affiliated businesses in such period (such amount, the "**Net Hospital Value**"), then Buyer agrees to convey to Seller or its designee immediately upon closing of such transaction by wire transfer of immediately available funds in an amount equal to twenty percent (20%) of the difference

between (i) the Net Hospital Value and (ii) the cash purchase price paid to Buyer in connection with such subsequent sale transaction. Notwithstanding anything to the contrary this Section shall not apply to (x) any sale required by a Governmental Authority, (y) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or relates to a broader group of facilities or assets than the Hospital Businesses, or (z) any corporate-level transactions involving PMH's stock or securities, including mergers, recapitalizations or reorganizations.

6.09. Charity Care and Community Obligations. Seller has historically provided significant levels of care for indigent and low-income patients. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will ensure that the Hospital maintains and adheres to Seller's current policies on charity care, attached as Schedule 6.09 for at least five (5) years from Closing. During all times that Buyer owns and operates the Hospital, Buyer will operate the Hospital's charity care program in accordance with Legal Requirements, and will continue to provide medically necessary services to the surrounding communities served by Seller. For a period of at least five (5) years after the Closing, Buyer shall (i) participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, (ii) accept all emergency patients without regard to ability to pay, (iii) maintain an open medical staff; (iv) provide public health programs of educational benefit to the community, and (v) generally promote public health, wellness, and welfare to the community by operating the Hospital with quality standards consistent with other hospitals owned by PMH, subject, in each case, in all respects to changes in governmental law, policy or regulation.

6.10. Capital Commitment. After the Closing, Buyer agrees to spend or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) not less than the Capital Amount in the seven (7) years following the Closing Date on capital projects, including routine and non-routine capital expenditures, at, or for the benefit of, the Hospital Businesses and/or the acquisition, development and improvement of hospital, ambulatory or other health care services in the greater Waterbury, Connecticut community, and which shall include, for the avoidance of doubt, expenditures relating to the implementation of PMH's coordinated regional care model (CRCM) and Physician Recruitment Expenditures. Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed after Closing that (i) discriminates against, or adversely or disproportionately affects for-stock or for-profit hospitals or other for-profit health care entities or (ii) causes Buyer to suffer a material decline in EBIDTA on a consolidated basis, then, in either event, Buyer shall be relieved of its obligation to provide the above capital commitment and shall be required to consult with the Local Board to determine an alternate mutually agreeable capital commitment of Buyer that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.

6.11. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements or in order to coordinate the defeasance of tax-exempt debt, Seller (and its Affiliates and Wholly Owned Subsidiaries) and Buyer (and its Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the

transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party.

(b) At all times before and after the Closing, Seller, on the one hand, and PMH and Buyer, on the other hand, will consult with the other before issuing or making any reports, statements or releases to the public with respect to this Agreement or the transactions contemplated by this Agreement and will use good faith efforts to obtain the other party's prior approval of the text of any public report, statement or release to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements, then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

6.12. Local Board. After Closing, Buyer shall form a local community advisory board comprised of between nine (9) and twelve (12) members (the "**Local Board**"). The Local Board shall include as members thereof the following individuals who shall serve in an *ex officio* capacity: (a) Chief of Medical Staff and (b) Head of Clinical Quality. In addition, a member of the board of directors of Buyer shall serve as a member of the Local Board and shall be selected to serve in such capacity by the board of directors of Buyer. The Local Board shall, among other things, (i) make recommendations and suggestions to Buyer regarding the mission, vision and value statements with respect to the Hospital and the Hospital Businesses; (ii) make recommendations and suggestions with respect to medical staff credentialing, disciplinary action of staff physicians, and compliance with accreditation requirements; (iii) provide input on policies and clinical programs; (iv) provide input in the development and review of strategic plans; (v) provide input on operating and capital budgets; (vi) provide input and support physician recruitment efforts; (vii) provide input on succession plans for executive leadership at the Hospital; (viii) promote community health initiatives, fostering community relationships and identifying service and education opportunities; and (ix) monitor the commitment to maintain and improve quality indicators.

6.13. Misdirected Payments, etc. Seller and Buyer covenants and agrees to remit, with reasonable promptness, to the other any payments received, which payments are on or in respect of accounts or notes receivable owned by (or are otherwise payable to) the other. In addition, and without limitation, in the event of a determination by any governmental or third-party payor that payments to Seller or the Hospital Businesses resulted in an overpayment or other determination that funds previously paid by any program or plan to Seller or the Hospital Businesses must be repaid, Seller shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered on or prior to the Closing Date, and the Buyer shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered after the Closing Date. In the event that, following Closing, the Buyer suffers any offsets against reimbursement under any third-party payor or reimbursement programs due to Buyer, relating to amounts owing under any such programs by Buyer or any of its Affiliates,

Seller shall immediately upon written demand from the Buyer pay to the Buyer the amounts so billed or offset.

6.14. Medical Staff Matters. Buyer shall adopt current bylaws and hearing procedures and otherwise work together with the Local Board and medical staff of the Hospital to preserve the existing staff membership and the current privileges of each physician, as well as the medical staff leadership.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

Notwithstanding anything herein to the contrary, the obligations of Seller to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Seller at the Closing:

7.01. Representations; Warranties. Each of the representations and warranties of Buyer contained in this Agreement that is qualified as to materiality was true and correct in all respects when made and shall be true and correct as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date, and each of the representations and warranties of Buyer contained in this Agreement that is not qualified as to materiality was true and correct in all material respects when made and shall be true and correct in all material respects as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Buyer on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

7.02. Governmental Matters. All material consents, authorizations, orders, and approvals of (or filings or registrations with) any Government Authority or other party required in connection with the execution, delivery, and performance of this Agreement shall have been obtained or made by Buyer when so required, except for any documents required to be filed, or consents, authorizations, orders, or approvals required to be issued, after the Closing Date.

7.03. Actions; Proceedings. No Proceeding before a court or any other Government Authority, unless resolved, shall have been instituted or threatened to restrain or prohibit the transactions herein contemplated, and no Government Authority shall have taken any other action or made any request of any party hereto as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

7.04. Insolvency. Buyer shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated a bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Buyer.

7.05. Closing Documents. All Closing Documents required to be delivered to Seller pursuant to Article 9 shall have been delivered to Seller.

8. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

Notwithstanding anything herein to the contrary, the obligations of Buyer to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Buyer at the Closing:

8.01. Representations; Warranties. Each of the representations and warranties of Seller contained in this Agreement that is qualified as to materiality was true and correct in all respects when made and shall be true and correct as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date, and each of the representations and warranties of Seller contained in this Agreement that is not qualified as to materiality was true and correct in all material respects when made and shall be true and correct in all material respects as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Seller on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

8.02. Pre-Closing Confirmations. Buyer shall have obtained documentation or other evidence satisfactory to Buyer in their sole discretion that Buyer has:

(a) Received satisfactory approval from all Government Authorities whose approval is required to complete the transactions herein contemplated (including, without limitation, satisfactory approvals, with conditions acceptable to Buyer in its sole discretion, of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein);

(b) Received confirmation from all applicable licensure agencies that, upon the Closing, either (i) all Permits required by law to operate the Hospital Businesses as currently operated will be transferred to, or issued or reissued in the name of, Buyer, or (ii) Buyer will be permitted to operate the Hospital Businesses as currently operated from and after the Closing until such time as all appropriate Permits are issued or reissued in the name of Buyer;

(c) Obtained reasonable assurances that Medicare and Medicaid certification of the Hospital Businesses, including the Hospital, for their operation by Buyer will be effective as of the Closing and that Buyer may participate in and receive reimbursement from such programs effective as of the Closing;

(d) Reasonably assured itself that all waiting periods under the HSR Act have been terminated or expired and that any additional approvals required from the Justice Department and/or the FTC relating to the transactions contemplated herein have been obtained and are in form and substance satisfactory to Buyer in its reasonable discretion;

(e) Obtained reasonable assurances that the material grants and grant programs listed on Schedule 8.02(e) shall continue after the Closing; and

(f) Obtained such other consents and approvals as may be legally or contractually required for the consummation of the transactions described herein.

8.03. Actions; Proceedings. No Proceeding before a court or any other Governmental Authority, unless resolved, shall have been instituted to restrain or prohibit the transactions herein contemplated, and no Governmental Authority shall have taken any other action or made any request of any party hereto as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

8.04. Adverse Change. Since the date hereof, no event or condition has occurred or exists that could reasonably be expected to cause a Material Adverse Effect.

8.05. Insolvency. Seller shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated a bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Seller.

8.06. Consents to Assignments. Consents (including consents to assignments), waivers, and estoppels of third parties, for those certain contracts and leases set forth on Schedule 8.06 from the counterparties to such contracts and leases, shall have been obtained, received by Buyer, and are in form and substance reasonably satisfactory to Buyer.

8.07. Vesting; Recordation. Seller shall have furnished to Buyer, in form and substance satisfactory to Buyer, assignments or other instruments of transfer and consents and waivers by others, necessary or appropriate to transfer to and effectively vest in Buyer all right, title, and interest in and to the Assets, in proper statutory form for recording if such recording is necessary or appropriate.

8.08. Due Diligence Investigation. Buyer shall have completed the due diligence investigation of the Hospital Businesses and the Assets, and the results of such investigation shall have been found satisfactory to Buyer in its sole and absolute discretion. **[Note: Assuming that the Agreement is executed at or near the time of closing, when the due diligence investigation will have been completed, Section 8.08 can be deleted.]**

8.09. Title Insurance Policies and Surveys. Buyer has received the Title Policy and the Surveys.

8.10. Loan Agreement. The Loan Agreement shall have been satisfied, discharged and terminated and all Encumbrances created by or in connection with the Loan Agreement shall have been released.

8.11. Waterbury Hospital Cash Balance Retirement Plan. Seller shall have taken all steps necessary to freeze the Waterbury Hospital Cash Balance Retirement Plan (the "**Cash Balance Plan**") effective as of the Closing Date so that no benefits, other than those required pursuant to a collective bargaining agreement, will accrue for any participant in the Cash

Balance Plan after the Closing Date, including providing any notice of such freeze as required under applicable laws.

8.12. Closing Documents. All Closing Documents required to be delivered to Buyer pursuant to Article 9 shall have been delivered to Buyer.

9. CLOSING; TERMINATION OF AGREEMENT

9.01. Closing.

(a) Consummation of the sale and purchase of the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at [_____] at 10:00 a.m. on the third (3rd) business day following satisfaction or waiver of the conditions to Closing set forth in Article 7, 8 and 9, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 9.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 9.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, PMH.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and Seller shall deliver (or cause to be delivered) to Buyer control and possession of the Assets.

9.02. Action of Seller at Closing. At the Closing, Seller shall deliver to Buyer:

(a) Special Warranty Deed, fully executed by Seller in recordable form, conveying to Buyer good and marketable fee title to the Owned Real Property, and Assignment and Assumption of Leases, fully executed by Seller in recordable form, assigning to Buyer leasehold title to the Leased Real Property, in each case subject only to current Taxes not yet due and payable as of the Closing Date and the Permitted Encumbrances;

(b) A General Assignment, Conveyance, and Bill of Sale, fully executed by Seller, conveying to Buyer good and marketable title to all tangible assets that are a part of the Assets and valid title to all intangible assets that are a part of the Assets,

free and clear of all liabilities, claims, liens, security interests, and restrictions other than the Assumed Liabilities and the Permitted Encumbrances (the "**Bill of Sale**");

(c) An Assignment and Assumption Agreement, fully executed by Seller, conveying to Buyer Seller's interest in the Assumed Contracts (the "**Assignment and Assumption Agreement**");

(d) All instruments, documents, and affidavits required by the Title Company to issue the Title Policy as described in and provided by Section 5.17 hereof that are consistent with the Connecticut Standards of Title;

(e) the Transitional Services Agreement, fully executed by Seller;

(f) Copies of resolutions duly adopted by the Board of Trustees of Seller, authorizing and approving the performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and of full force as of the Closing, by the appropriate officers or other representatives of Seller;

(g) A certificate of the President or a Vice President of Seller certifying that each covenant and agreement of Seller to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of Seller is true and correct on the Closing Date, as if made on and as of the Closing;

(h) Certificates of incumbency for the officers or representatives of Seller executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(i) Certificates of existence of Seller from the state in which it is incorporated, dated the most recent practical date prior to the Closing;

(j) All Certificates of Title and other documents evidencing an ownership interest conveyed as part of the Assets, including all JV Interests;

(k) An affidavit stating that Seller is not a "foreign person" as defined in Section 1445(f)(3) of the Code, as amended;

(l) All necessary state and local real estate conveyance Tax forms duly executed by Seller;

(m) Final execution copy of the Transfer Act Form III and ECAF, as more fully described in Section 5.06;

(n) Limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers, in substantially the form of Exhibit B attached hereto, fully executed by Seller; and

(o) Such other instruments and documents as Buyer reasonably deems necessary to effect the transactions contemplated hereby.

9.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) The Purchase Price due to Seller (less the Indemnification Holdback Amount) as adjusted in accordance with Section 2.05;

(b) Copies of resolutions duly adopted by the Board of Directors of PMH and Buyer authorizing and approving the performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and in full force as of the Closing, by the appropriate officers of PMH and Buyer;

(c) A certificate of the President or a Vice President of Buyer certifying that each covenant and agreement of Buyer to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of Buyer is true and correct on the Closing Date, as if made on and as of the Closing;

(d) A certificate of incumbency for the respective officers of PMH and Buyer executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(e) Certificates of existence and good standing of Buyer from the state in which Buyer is formed or incorporated, dated the most recent practical date prior to Closing;

(f) Such other instruments and documents as Seller reasonably deems necessary to effect the transactions contemplated hereby;

(g) The Transitional Services Agreement, fully executed by Buyer;

(h) Final execution copy of the Transfer Act Form III and ECAF with a $3,000 filing fee[12], as more fully described in Section 5.06; and

(i) Such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this Agreement.

9.04. Termination Prior to Closing.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller, if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Article 8; (iii) by Seller, by written notice to Buyer, if any event occurs or condition exists that causes Buyer to be

[12] Under review

unable to satisfy one or more conditions to the obligations of Seller to consummate the transactions contemplated by this Agreement as set forth in Article 7; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before [_____] (*provided, however*, that, Buyer shall have the right, exercisable upon prior written notice to Seller, to extend such date by up to an additional thirty (30) days if all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied other than the receipt of approvals from all governmental authorities whose approval is required to complete the transactions herein contemplated, but only if Buyer is diligently pursuing such remaining governmental approvals or contesting in good faith any of the terms or conditions of such approvals, including, without limitation, pursuing any changes in respect of the conditions imposed on the operation of the Hospital or the related businesses or any other modifications set forth in such approval); *provided, however*, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; or (v) by Buyer, pursuant to Section 5.08.

(b) If this Agreement is validly terminated pursuant to Section 9.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 9.04(a), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity, (ii) the termination fee provisions of Section 9.04(d), the expense allocation provisions of Section 11.21 and the confidentiality provisions of Section 6.11 shall remain in full force and effect and survive any termination of this Agreement.

(c) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing.

(d) In the event that this Agreement is terminated by:

(i) Buyer for any reason other than pursuant to Section 9.04(a)(ii) or Section 9.04(a)(iv);

(ii) by Seller pursuant to Section 9.04(a)(iii) due to the occurrence of any event or existence of any condition that causes Buyer to be unable to satisfy the conditions to the obligations of Seller to consummate the transactions

contemplated by this Agreement as set forth in Sections 7.01, 7.04 or 7.05 (*provided,* that, with respect to Section 7.05, all closing conditions have been satisfied or waived, other than the conditions that by their terms are to be satisfied by actions to be taken at the Closing, provided that such actions are, as of the time of such termination, capable of being satisfied at the Closing); or

(iii) by Seller pursuant to Section 9.04(a)(iv) and at the time of such termination (x) all the conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Section 8 have been satisfied (other than the conditions that by their terms are to be satisfied by actions to be taken at the Closing, provided that such actions are, as of the time of such termination, capable of being satisfied at the Closing), and (y) Seller is in compliance in all material respects with the terms of this Agreement,

then Buyer shall, within five (5) business days after receipt of written notice of such termination, pay to Seller by wire transfer of immediately available funds to an account designated by Seller a fee equal to One Million Dollars ($1,000,000) (the "**Termination Fee**").

(e) This Section 9.04 shall survive any termination of this Agreement.

10. INDEMNIFICATION

10.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent provided in this Article 10, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any inaccuracy in or breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof;

(b) any claim asserted against Buyer or Buyer's Affiliates that, if meritorious, would constitute or give rise to a breach of any of Seller's representations and warranties as the direct cause of such claim;

(c) the nonfulfillment or breach of any covenant of Seller set forth in this Agreement or in any Closing Document to which Seller is a party;

(d) the Excluded Liabilities; and

(e) any claim made by a third party with respect to the operation of the Hospital Businesses prior to the Closing Date.

10.02. Seller's Limitations. Seller will have no liability under Section 10.01(a) and no claim will accrue against Seller under Section 10.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 10.01(a) exceeds $150,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's

Indemnified Persons shall be entitled to indemnification for all Losses under Section 10.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Seller shall arise for all Losses, in respect of Losses resulting from Seller's intentional misrepresentation or fraud, *provided, further*, that Seller's liability for indemnification under Section 10.01(a) shall be limited to an amount equal to $3,000,000.

10.03. Indemnification by Buyer. Subject to the conditions and limitations, and solely to the extent, provided in this Article 10, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) the inaccuracy in or breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof;

(b) the nonfulfillment or breach of any covenant of Buyer in this Agreement or in any Closing Document to which Buyer is a party;

(c) the Assumed Liabilities; and

(d) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing Date.

10.04. Buyer's Limitations. Buyer will have no liability under Section 10.03(a) and no claim will accrue against Buyer under Section 10.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 10.03(a) exceeds $150,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 10.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Buyer, *provided, further*, that Buyer's liability for indemnification under Section 10.03(a) shall be limited to an amount equal to $3,000,000.

10.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this Article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 10 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a reasonable summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and

related materials) to the Indemnifying Party within 60 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in this Section 10.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided, further*, that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 10.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more of Buyer's Indemnified Persons and one or more of Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical

rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of Section 10.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided, however*, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld or delayed) and (B) the out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates).

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within 60 days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 60-day period in which to respond pursuant to Section 10.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be attempted to be resolved pursuant to Section 11.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within 10 days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 11.19.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 10.05(a)(i) and Section 10.05(b)(i), as applicable.

10.06. Survival of Representations and Warranties; Indemnity Periods. All of the representations, warranties, covenants, and agreements made by the parties in this Agreement or pursuant hereto in any certificate, instrument, or document shall survive the consummation of the transactions in the manner described herein, and may be fully and completely relied upon by Seller, Buyer, and PMH, as the case may be, notwithstanding any investigation heretofore or hereafter made by any of them or on behalf of any of them, and shall not be deemed merged into any instruments or agreements delivered at the Closing or thereafter. Each party acknowledges that no representations or warranties are made except as specifically set forth herein. Notwithstanding anything in this Section 10.06 that may be to the contrary, any claim, demand, or cause of action with respect to a breach of any representation or warranty made in this Agreement (other than representations or warranties contained in Sections 3.01 (Organization and Qualification), 3.02 (Corporate Powers; Absence of Conflicts, Etc), 3.03 (Binding Agreement), 3.04 (Investments and Third Party Rights), 3.10 (Title), 3.28 (Joint Ventures), 4.01 (Organization), 4.02 (Power and Authority; Due Authorization), 4.03 (Consents; Absence of Conflicts, Etc.), 4.04 (Due Execution; Binding Agreement), which shall survive indefinitely, and the representations or warranties contained in Sections 3.05 (Legal and Regulatory Compliance), 3.12 (Environmental Laws), 3.16 Government Payment Programs; Accreditation; Payor Cost Reports), 3.21 (Employee Benefit Plans), 3.25 (Restricted Assets), and 3.23 (Taxes), which shall

survive the longer of five (5) years or 90 days after the expiration of the applicable statute of limitations pertaining to the underlying claim, including extensions and waivers), must be made or brought, if at all, within eighteen (18) months after the Closing Date. For the avoidance of doubt, this Section 10.06 shall not affect any rights to bring claims after eighteen (18) months based on (a) any covenant or agreement of the parties that contemplates performance after the Closing, (b) the obligations of Seller under Sections 10.01(c), (d) and (e) (Indemnification by Seller), (c) the obligations of Buyer under Sections 10.03(b), (c) and (d) (Indemnification by Buyer), or (e) the obligations of the parties under Section 10.07 (Mitigation).

10.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any Third Party Claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

10.08. Calculation of Losses. Solely for the purpose of calculating the amount of any Losses arising out of or resulting from any breach of any representation or warranty contained in this Agreement (and not for determining the existence of any breach of any representation or warranty contained in this Agreement), any reference to a "material", "materiality" or "Material Adverse Effect" or other correlative terms in such representation or warranty shall be disregarded.

10.09. Indemnification Holdback.

(a) Buyer shall be entitled to apply against the Indemnification Holdback Amount any unpaid amounts due to Seller pursuant to Section 2.05(h).

(b) The Buyer's Indemnified Persons shall be entitled to be reimbursed from the Indemnification Holdback Amount for any Losses arising from Section 10.01, and from time to time during the three (3) year period immediately following the Closing Date, on not less than ten (10) days' notice to Seller, Buyer (or PMH) shall be entitled to apply some or all of the Indemnification Holdback Amount if and to the extent any of the Buyer's Indemnified Persons incur any Losses under Section 10.01.

(c) Any Indemnification Holdback Amount remaining following the three (3) year period identified in Section 10.09(a), and subject to the last sentence of this Section 10.09(b), shall be released, with simple interest thereon, which interest shall accrue at a rate equal to four percent (4%) per annum from the Closing Date (as if the amount of such Indemnification Holdback Amount being released to Seller had been fixed at Closing), to Seller within thirty (30) days following the applicable survival date set forth in Section 10.06 ("**Indemnification Holdback Survival Date**") by wire transfer of immediately available funds to such account or accounts of Seller as Seller specifies in writing to Buyer in the manner specified herein for the delivery of notices. Notwithstanding the terms of the preceding sentence, if Buyer has submitted a notice for indemnification or other Losses exist on or prior to the Indemnification Holdback Survival Date and such indemnification claim is not finally determined until after the Indemnification Holdback Survival Date, a portion of such remaining Indemnification Holdback Amount that, in the reasonable judgment of Buyer, is sufficient to satisfy any shortfall amounts under Section 2.05(h) or any potential unsatisfied claims or Losses (including, if applicable, reasonable attorney's fees) shall be retained by Buyer until such shortfall amounts, claims or Losses, as applicable, have been resolved and shall not be released as provided above until after such shortfall amounts are paid, such indemnification claim shall have been finally determined or such Losses shall have been finally quantified and any indemnification payments (through application of funds from the remaining Indemnification Holdback Amount) to Buyer or any Buyer's Indemnified Persons, as applicable, have been made.

(d) For clarity, in no event shall the Indemnification Holdback Amount be deemed to be in any respect a cap on (i) the amount of any shortfall which Buyer shall be entitled to apply against the Indemnification Holdback Amount pursuant to Section 2.05(h) and Section 10.09, or (ii) the amount of any Losses for which the Buyer's Indemnified Persons shall be entitled to recover pursuant to Section 10.01 and Section 10.09.

11. GENERAL

11.01. Exhibits; Schedules. Each Exhibit and Schedule to this Agreement shall be considered a part hereof as if set forth herein in full.

11.02. Equitable Remedies. Each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the

availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 10).

11.03. Other Owners of Assets. Buyer, Seller and its undersigned Wholly Owned Subsidiaries acknowledge that certain Assets may be owned by Wholly Owned Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Wholly Owned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Wholly Owned Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Wholly Owned Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Wholly Owned Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement.

11.04. Dispute Resolution. The parties hereby agree that, prior to pursuing any other legal remedy, any controversy or claim arising out of this Agreement shall be attempted to be resolved through the following procedures:

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party written notice of such dispute pursuant to Section 11.14, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 11.04(a) within 30 days of the written notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within 15 days after receipt of written notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

11.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions

provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

11.06. Reproduction of Documents. This Agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

11.07. Consented Assignment. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Assumed Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller shall cooperate in any reasonable arrangement designed to provide for Buyer the benefits under any such Assumed Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise but shall not be required to commence litigation. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such Assumed Contract, claim or right; *provided, however*, that such obligation shall be of no further force and effect if Seller and Buyer determine that such consent or approval will not be forthcoming.

11.08. Time of Essence. Time is of the essence in the performance of this Agreement, *provided* that, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Manchester, Connecticut are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Waterbury, Connecticut are permitted or required to be closed. The parties will use commercially reasonable efforts to file as soon as practicable and pursue all necessary regulatory approvals required in connection with this Agreement.

11.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

11.10. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or

any other jurisdiction). Any litigation or proceedings among the parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

11.11. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate one or more Affiliates to purchase any or all of the Assets, including the Hospital Businesses, provided that PMH shall unconditionally guarantee any and all obligations of such Affiliates pursuant to Section 11.22, and (ii) Buyer and PMH shall be permitted to grant a security interest in and collaterally assign and transfer all their rights, interests and benefits, but not their obligations, under this Agreement to any entity providing financing to Buyer and/or Buyer's Affiliates at any time and from time to time without obtaining the written consent of Seller.

11.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms (except as otherwise provided in Section 5.03(d)).

11.13. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by the other party of any provision of this Agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this Agreement, or (c) any other right or remedy permitted the waiving party in this Agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by the party entitled to the benefit of the provision, condition, right or remedy to be waived, and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies.

11.14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) three (3) days after the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: c/o Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd.. Suite 400
Los Angeles, CA 90025
Attn: General Counsel
Fax: 310-943-4501
Email: ellen.shin@prospectmedical.com

with a copy to (which shall not constitute notice):

Epstein Becker & Green, P.C.
1 Gateway Center
Newark, NJ 07102
Attn: Gary W. Herschman
Email: GHerschman@ebglaw.com
Attn: David E. Weiss
Email: DWeiss@ebglaw.com

If to Seller: Greater Waterbury Health Network, Inc.
Attn: President
Fax: 203-573-6161
Email: dstromstad@wtbyhosp.org

with a copy to (which shall not constitute notice):

Carmody Torrance Sandak & Hennessey, LLP
707 Summer Street, Suite 300
Stamford, CT 06901
Attn: Ann Zucker, Esq.
Fax: 203.252.2686
Email: azucker@carmodylaw.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section.

11.15. Severability. If any provision of this Agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this Agreement would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; (c) the remainder of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this Agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

11.16. CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate Governmental Authority shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

11.17. Entire Agreement; Amendment. Except as set forth in Section 11.21(a), this Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 10.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

11.18. Counterparts; Transmission by Electronic Means. 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. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

11.19. Interest. Any monies required to be paid by any party to another party pursuant to this Agreement shall be due on the date or at the time for payment specified in this Agreement, and monies not paid when due shall accrue interest from and after the due date to, but not including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A. during such period.

11.20. Drafting. No provision of this Agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this Agreement.

11.21. Fees and Expenses.

(a) Except as otherwise expressly set forth in this Agreement and the Letter of Intent, dated April 30, 2015, by and between Seller and PMH, whether or not the transactions contemplated by this Agreement are consummated, (i) Buyer or its Affiliates shall bear and pay all expenses incurred by or on behalf of Buyer in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Agreement and Buyer's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) Seller shall bear and pay all expenses incurred by or on behalf of Seller, or its Affiliates or Wholly Owned Subsidiaries, in connection with the preparation and negotiation of this Agreement and Seller's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than $1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all transfer Taxes, sales and use and similar Taxes arising out of the transfer of the Assets (whether or not originally arising with or assessed to Seller or its applicable Wholly Owned Subsidiary) and (iii) the premium for Buyer's title insurance policies described in Section 8.09.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Agreement and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

11.22. Guarantee of Buyer's Obligations. PMH, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, PMH will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 10.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. PMH obligations under this Section

11.22 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

11.23. Liquidated Damages.

(a) The parties acknowledge that: (i) the agreements contained in Section 9.04(d) are an integral part of the transactions contemplated by this Agreement; (ii) without these agreements, the parties would not enter into this Agreement; (iii) it would be extremely difficult and impracticable, if not impossible, to ascertain with any degree of certainty the amount of damages that would be suffered by Seller in the circumstances in which the Termination Fee is payable; and (iv) the Termination Fee is not a penalty, but rather is liquidated damages in a reasonable amount, negotiated as the parties' reasonable estimate of Seller's damages in the circumstances in which the Termination Fee is payable. Notwithstanding anything to the contrary in this Agreement, Seller's right to receive payment of the Termination Fee pursuant to Section 9.04(d) shall be the sole and exclusive remedy of Seller or any of its Affiliates against Buyer, PMH or any of their respective Affiliates or any of their respective stockholders, partners or members for any and all losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with Section 9.04(d), none of Buyer, PMH or any of their respective Affiliates or any of their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(b) If Buyer fails to pay the Termination Fee pursuant to Section 9.04(d) when due and, in order to obtain such payment, Seller commences a suit or suits that result in a judgment or judgments against Buyer for the Termination Fee, then Buyer shall pay to Seller its costs and expenses (including attorneys' fees and expenses) in connection with such suit and the collection and enforcement of such judgment(s), together with interest on the amount of the Termination Fee from the date such payment was required to be made until the date of payment at the "prime rate" of Bank of America, N.A. in effect on the date such payment was required to be made.

[*Signature Page Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____

Title: _____

[BUYER]

By: _____

Title: _____

PROSPECT MEDICAL HOLDINGS, INC.
(only with respect to Section 11.22)

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Wholly Owned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 11.03.

ACKNOWLEDGED BY:

THE WATERBURY HOSPITAL

By: _____

Title: _____

[OTHER ENTITIES]

By: _____

Title: _____

[OTHER ENTITIES]

By: _____

Title: _____

Exhibit A

Form of Transitional Services Agreement

See attached.

Exhibit B

Form of Limited Power of Attorney

See attached.

Exhibit C

Essential Clinical and Other Services

[Comment: To be determined based on diligence]

Buyer shall provide the following essential clinical and other services: (a) Emergency Department/Services (including trauma services), (b) General Medicine, (c) Behavioral Health Services, (d) Inpatient and Outpatient Surgery, (e) Radiology and Diagnostic Services, (f) Obstetrics and Gynecology (including those reproductive services currently provided at the Hospital), (g) Cardiology Services including Open Heart Services, (h) Intensive Care Services, and (i) Neonatal Intensive Care Services (each, an "**Essential Service**"); *provided, however*, that if any of the following contingencies occurs with regard to any particular Essential Service, the Buyer may suspend, terminate, discontinue or materially and substantially modify, limit, or reduce (as applicable) the Essential Service:

(i) The medical staff of the facilities then owned or operated by the Buyer do not include qualified physicians necessary to support the provision of the Essential Service;

(ii) An Essential Service experiences a significant decrease in patient volumes for any reason not within the reasonable control of the Buyer, including technological obsolescence, changes in method, techniques or sites for delivery of the Essential Service, pharmaceutical advancements, failure of the Essential Service to qualify for reimbursement under Medicare (or any successor program) or a material portion of other payors, demographic and other market changes, or other competitive/marketplace factors; or

(iii) The actual or projected volume or clinical staffing for an Essential Service is or will be insufficient to achieve or maintain the level of quality for such Essential Service that is at least equal to, or better than, the level of quality at which the Essential Service is provided at any other general acute care community hospital in the region.

Annex A

Calculation Methodology for Net Working Capital

Schedule 1.02

Persons with "Seller's Knowledge"

[●]	President and Chief Executive Officer
[●]	Senior Vice President and Chief Operating Officer
[●]	Vice President/Chief Financial Officer
[●]	Vice President Medical Affairs/Chief Medical Officer
[●]	Vice President Patient Care/Chief Nursing Officer
[●]	Vice President Information Services/Chief Information Officer
[●]	Chief Medical Information Officer
[●]	Vice President Human Resources
[●]	Director – Compliance and HIPAA
[●]	Assistant Director Finance – Corporate Accounting
[●]	Corporate Compliance Officer
[●]	Administrative Director Facility Operations

Schedule 3.04

[Insert organizational chart with ownership/membership percentages]

EXHIBIT Q3-3

BALANCE SHEET OF PROPOSED TRANSACTION

EXHIBIT Q3-3
BALANCE SHEET FOR THE PROPOSED TRANSACTION

	Balance Sheet as of 8/31/2015 (Ownership Adjusted)	Pro Forma			
		Retained by Surviving Entity	Purchased/ Assumed by Prospect	Purchase Adjustments	Prospect Opening Balance Sheet
Assets					
Current Assets:					
Cash and Cash Equivalents	$ 12,752,652	$ 12,752,652	$ -	$ 10,000,000	$ 10,000,000
Short-term Investments	$ 1,511,197	$ 1,511,197	$ -		$ -
Net Accounts Receivable	$ 34,693,504	$ 124,534	$ 34,568,970		$ 34,568,970
Accts Receivable - Other	$ 4,046,064	$ 3,594,000	$ 452,064		$ 452,064
Inventories	$ 4,016,702	$ -	$ 4,016,702		$ 4,016,702
Prepaid Insurance and Other Expenses	$ 2,774,184	$ 617,654	$ 2,156,530		$ 2,156,530
Due From Affiliates	$ 171,849	$ 171,849	$ -		$ -
Total Current Assets	$ 59,966,152	$ 18,771,886	$ 41,194,266	$ 10,000,000	$ 51,194,266
Noncurrent Assets Who Use Is Limited:					
CHEFA Bond Issue Cost	$ 229,450	$ 229,450	$ -		$ -
Investments	$ 26,778,686	$ 26,778,686	$ -		$ -
Board Designated Funds	$ 3,347,474	$ 3,347,474	$ -		$ -
Loans and Other Receivables	$ 253,069	$ 253,069	$ -		$ -
Funds Held in Trust by Others	$ 44,395,266	$ 44,395,266	$ -		$ -
Goodwill	$ 1,813,567	$ -	$ 1,813,567	$ (1,813,567)	$ -
Net PP&E	$ 31,804,176	$ 2,073,100	$ 29,731,077	$ 1,768,923	$ 31,500,000
Total Assets	**$ 168,587,842**	**$ 95,848,931**	**$ 72,738,910**	**$ 9,955,356**	**$ 82,694,266**
Liabilities					
Current Liabilities					
Accounts Payable and Accrued Expenses	$ (22,759,485.99)	$ (2,831,346)	$ (19,928,139.73)	$ -	$ (19,928,139.73)
Current Portion of Accrued Pension Liablility	$ (3,388,000)	$ -	$ (3,388,000)		$ (3,388,000.00)
Intercompany Liabilities				$ (10,000,000)	$ (10,000,000.00)
Current Portion of Long Term Debt	$ (946,569)	$ (946,569)			$ -
Due to Third-Party Payors	$ (4,946,513)	$ (4,946,513)	$ -		$ -
Total Current Liabilities	$ (32,040,568)	$ (8,724,428)	$ (23,316,140)	$ (10,000,000)	$ (33,316,140)
Long-Term Debt	$ (24,596,339)	$ (24,771,328)	$ 174,989	$ (6,500,000)	$ (6,325,011)
Other Long-Term Liabilities:					$ -
Workers Compensation	$ (12,542,831)	$ (12,542,831)	$ -	0	$ -
Pension	$ (8,997,599)	$ -	$ (8,997,599)	0	$ (8,997,599)
Malpractice	$ (2,013,331)	$ -	$ (2,013,331)	$ 2,013,331	$ -
Asbestos Abatement	$ (2,801,923)	$ -	$ (2,801,923)	0	$ (2,801,923)
Other Long-Term Liabilities	$ (2,042,155)	$ (2,042,155)	$ -		$ -
Total Other Liabilities	$ (52,994,178)	$ (39,356,314)	$ (13,637,865)	$ (4,486,669)	$ (18,124,534)
Total Liabilities	**$ (85,034,746)**	**$ (48,080,742)**	**$ (36,954,004)**	**$ (14,486,669)**	**$ (51,440,674)**
Net Assets	$ 83,553,095	$ 47,768,189	$ 35,784,906	$ (4,531,313)	$ 31,253,593
Net Balance Sheet Items	**$ 168,587,842**	**$ 95,848,931**	**$ 72,738,910**	**$ 9,955,356**	**$ 82,694,266**

EXHIBIT Q4-1

MUTUAL NON-DISCLOSURE AGREEMENT

MUTUAL NON-DISCLOSURE AGREEMENT

THIS MUTUAL NON-DISCLOSURE AGREEMENT ("Agreement") is entered into as of March 9, 2015 (the "Effective Date"), by and among **Prospect Medical Holdings, Inc.** a Delaware corporation, on behalf of and together with its affiliates ("Prospect") and **Greater Waterbury Health Network, Inc.**, on behalf of and together with its affiliates ("GWHN"). (Prospect and GWHN are each referred to herein as a "Party" and collectively as the "Parties").

RECITALS

WHEREAS, the Parties desire to share certain confidential and proprietary information about each other (as defined in Section 1, the "Confidential Information") in order to jointly evaluate potential collaboration options to improve quality and access to care for their patient populations, including, without limitation, a potential affiliation between Prospect and GWHN (the "Proposed Arrangement");

WHEREAS, each Party agrees to keep the Confidential Information it receives from the other Party confidential and not to disclose such Confidential Information, and to be bound by the terms and conditions of this Agreement; and

NOW THEREFORE, in consideration for the mutual exchange of the Confidential Information, the covenants of non-disclosure and confidentiality and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as set forth below:

1. Mutual Exchange of Confidential Information. In connection with their evaluation of the Proposed Arrangement, the Parties have agreed to share certain confidential and proprietary information. Each Party will hold in confidence any and all Confidential Information that it has received from or disclosed to, or will receive from or disclose to, the other Party while reviewing the feasibility of the Proposed Arrangement.

    a. Confidential Information shall include, without limitation, the identity of the Party making the disclosure (the "Discloser"), reports, memoranda, statistics, forms, notes, records, financial information, patient lists, charts, know-how, work-in progress, trade secrets, business methods and processes, legal documents or any other matter relating to the business of any Party (regardless of whether orally, on paper, electronically, or in any other form) or information verbally disclosed ("Confidential Information").

    b. The term "Confidential Information" does not include any such information that is/was: (a) already available or that becomes available to the public through no fault of the receiving Party ("Recipient"); (b) received by Recipient from a third party having a right to disclose it; (c) developed by Recipient independent of any disclosure under this Agreement, as reasonably shown by the Recipient; or (d) approved for release by written authorization of the Discloser.

2. Confidentiality and Non-Disclosure. As a condition to receiving the Confidential Information, each Party agrees to treat the Confidential Information, whether furnished before, on or after the Effective Date, in accordance with the terms and provisions of this Agreement.

3. Persons and Affiliates. As used in this Agreement: (a) the term "person" means any entity, individual or group of individuals, including without limitation, any corporation, company, group, syndicate, or partnership; and (b) the term "affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, a specified person.

4. Use of Confidential Information. Each Party hereto: (a) acknowledges and agrees that all Confidential Information of the other Party shall be deemed confidential and proprietary, shall be treated as such, and shall not be disclosed, either within the Recipient or to a third party, other than in accordance with this Agreement; (b) agrees to use the Confidential Information solely for the purpose of evaluating, negotiating and/or implementing the Proposed Arrangement, and for no other purpose; and (c) agrees not to reproduce the Confidential Information of the other Party in any form, except as necessary for such evaluation, negotiation, or implementation. Each Party agrees that it shall not, without the other Party's prior written consent, disclose such Confidential Information to anyone except its own employees, agents, affiliates, directors and officers, representatives, legal counsel and/or financial advisors, who need such Confidential Information for the purposes set forth above and, who are aware of, subject to, and agree to be bound by, this Agreement. The Recipient shall require and cause any person granted access to the Confidential Information to adhere to the terms of this Agreement and shall be responsible for any breach of this Agreement. Recipient agrees to notify the Discloser in writing as soon as practicable of any misuse or misappropriation of the Confidential Information that comes to the Recipient's attention.

5. Compliance with Laws. Each Party confirms that it will not disclose any Confidential Information in violation of any laws and shall not use the other party's Confidential Information in any manner that would violate any laws.

6. Confidentiality of Negotiations. Each Party agrees that it will not disclose, and will prevent its directors, officers, employees, agents and advisors from disclosing, to any person: (a) that discussions or negotiations are taking place concerning the Proposed Arrangement; or (b) any of the terms, conditions or the facts with respect to the Proposed Arrangement, including the status thereof.

7. Compelled Disclosure. In the event that the Recipient is at any time requested or required (by oral questions, interrogatories, requests for information or documents, subpoena or similar process) to disclose any of the Confidential Information of the Discloser, the Recipient shall provide the Discloser with prompt notice of such request and the documents and/or information requested thereby so that the Discloser may seek an appropriate protective order and/or waive the Recipient's compliance with the provisions of this Agreement. The Parties hereto further agree that, if in the absence of protective order or the receipt of a waiver hereunder, the Recipient reasonably believes, based on the written advice of counsel, that it is nonetheless compelled to disclose any

Confidential Information of the Discloser to any tribunal or governmental body, the Recipient may disclose to such tribunal or governmental body without liability hereunder that portion of such Confidential Information that it is compelled to be disclosed; provided, however, that the Recipient shall give the Discloser written notice of the information to be so disclosed as far in advance of its disclosure as practicable and shall use its reasonable best efforts to obtain an order or such reliable assurance that confidential treatment will be accorded to such portion of the information required to be disclosed as the Discloser designates.

8. Return or Destruction of Confidential Information. Upon the request of either Party hereto, the other Party: (a) shall promptly return to the requesting Party or destroy all Confidential Information of the requesting Party and all written materials containing or reflecting any information contained in such Confidential Information; and (b) shall not retain any copies, extracts or other reproductions in whole or in part of such written material. All documents, memoranda, notes and other writings whatsoever based on the information in the Confidential Information requested to be returned shall be destroyed by the Party in possession thereof, and such destruction shall be certified in writing to the requesting Party. Notwithstanding anything to the contrary in this Agreement, the Parties shall not be required to return or destroy copies of any computer records or files containing Confidential Information which have been created pursuant to automatic archiving and back-up procedures and which cannot reasonably be returned or destroyed. The retention, return, or destruction of such materials, as applicable, shall not relieve the Parties hereto of their respective confidentiality, non-disclosure, and non-use obligations hereunder.

9. No Implied Rights. Except as expressly set forth herein, this Agreement shall not confer upon either Party, or be a basis for implying, any rights of any kind in the Confidential Information of the other Party.

10. Waiver and Amendment. No failure or delay by a Party in exercising its rights hereunder shall operate as a waiver or preclude any further or other exercise of such rights. No provision of this Agreement may be waived or amended unless such waiver or amendment is in writing, designated as a waiver or amendment to this Agreement, and if an amendment, signed by both Parties. This Agreement constitutes the entire agreement of the Parties with respect to the subject matter hereof.

11. Equitable Remedies. The Parties agree that owing to the nature of this Agreement and the Confidential Information, money damages would not be a sufficient remedy for any breach of this Agreement and that either Party shall be entitled to specific performance and injunctive and/or other equitable relief as a remedy for any such breach by the other Party. Each Party hereby consents to any such remedy and further agrees to waive any requirement for the securing or posting of any bond in connection with such remedy. Such remedy shall not be deemed to be the exclusive remedy for breach of this Agreement, but shall be in addition to all other remedies available at law or equity. If any legal action relating to this Agreement is brought by a Party against another Party, the prevailing Party shall be entitled to recover its reasonable costs, expenses, and attorneys' fees.

12. No Warranty. Neither Discloser nor any of its representatives makes, or shall be deemed to have made, any representation or warranty, express or implied, as to the accuracy or

completeness of any Confidential Information disclosed pursuant to this Agreement, and neither Discloser nor any of its respective representatives shall have any liability to Recipient arising out of or resulting from any use of the Confidential Information or any errors or omissions that may be contained therein.

13. Notices. Notices or communications required or permitted to be given under this Agreement shall be given to the respective Parties by hand or by registered or certified mail (said notice being deemed given as of the date of mailing) at the following addresses unless a Party shall otherwise designate its address by notice:

If to Prospect:

Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025
Attention: Legal Department

If to GWHN:

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06721
Attn: President and Chief Executive Officer

With a Copy to:

Ann H. Zucker, Esq.
Carmody Torrance Sandak & Hennessey LLP
707 Summer Street
Stamford, CT 06901

14. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut.

15. Counterparts. This Agreement may be executed in one or more counterparts, and by facsimile signatures, each of which shall be an original document, and all of which together shall constitute one and the same instrument.

16. Term; Termination. This Agreement will terminate upon the later of one (1) year from the effective date or when all confidential information has been returned to each respective Discloser. The parties' duties of confidentiality with respect to the other party's Confidential Information shall extend for four years after the termination or expiration of this Agreement.

[Signature Page Follows.]

IN WITNESS WHEREOF, the Parties hereby execute this Agreement on the above Effective Date.

PROSPECT MEDICAL HOLDINGS, INC.

By: _____

Its: VICE PRESIDENT, CORP DEVELOPMENT

GREATER WATERBURY HEALTH NETWORK, INC.

By: Darlene Stromstad

Its: President and Chief Executive Officer

{NS070995}

EXHIBIT Q4-2: CONSULTING AGREEMENT

□W2602308□

EXECUTION VERSION

INTERIM CONSULTING AGREEMENT

THIS INTERIM CONSULTING AGREEMENT (this "Agreement") is made and entered into as of the 27 day of October, 2015 (the "Effective Date") by and between Prospect Medical Holdings, Inc., a Delaware corporation ("Prospect," and collectively with its Affiliates (as defined below), "Advisor"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("GWHN").

RECITALS

A. GWHN, together with its Affiliates (collectively, the "Company"), operates The Waterbury Hospital (the "Hospital") which serves the needs of residents of the greater Waterbury, Connecticut area.

B. On April 30, 2015, Advisor entered into a Letter of Intent with the Company, as amended by that certain Amendment No. 1 to Letter of Intent dated August 28, 2015, by that certain Amendment No. 2 to Letter of Intent dated September 10, 2015, and by that certain Amendment No. 3 to Letter of Intent dated September 14, 2015 (as so amended, the "Letter of Intent") which sets forth certain terms and conditions pursuant to which Advisor, or an Affiliate of Advisor, would acquire the businesses of the Company pursuant to the terms of a definitive Asset Purchase Agreement to be negotiated and entered into by GWHN and Advisor, the form of which is being filed in connection with the parties' application for CON Approvals (as defined below) (the "Purchase Agreement"). Defined terms used but not defined herein shall have the meanings set forth in the Letter of Intent. References contained herein to Sections and Section numbers of the Purchase Agreement shall be deemed to refer to any successor provisions thereto, as the case may be.

C. The Letter of Intent provides, among other things, that the term of the Letter of Intent shall continue in effect until the earlier of (x) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the Letter of Intent, (y) one hundred eighty (180) days following the receipt by the parties of the certificate of need approval for the Hospital by the Office of Healthcare Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Office of the Attorney General of the State of Connecticut (the "CON Approvals"), subject to Prospect's right to extend the Letter of Intent term up to an additional one hundred eighty (180) days if Prospect is diligently contesting in good faith any of the terms or conditions of such CON Approvals (as set forth in greater detail in the Letter of Intent).

D. The Purchase Agreement is expected to set forth various conditions to Closing (including regulatory approvals), but pursuant to Connecticut law, the Purchase Agreement cannot be executed by the parties until receipt of the CON Approvals. Furthermore, even after the Purchase Agreement is executed, the various conditions (including regulatory approvals) to Closing set forth therein may take months to satisfy or obtain.

E. Given the contracting restrictions imposed upon the parties by the State of Connecticut, the parties seek to confirm in writing that this Agreement is intended to continue until the closing of the transactions contemplated in the Letter of Intent (and, more specifically,

in the Purchase Agreement) and that should this Agreement terminate, Advisor shall be entitled to be paid its Consulting Service Fees (as defined below) in accordance with, and to the extent provided by, Section 6.5 hereof.

F. Advisor, through its executives and other personnel, has certain experience and expertise in the management, operations, financial and administrative aspects of businesses like that of the Company.

G. Advisor is willing to provide certain consulting services, as described on Exhibit A hereto (the "Consulting Services"), with the objective of improving and otherwise benefitting the operations of the Company and the Hospital during the time period from the Effective Date through the Closing of the Purchase Agreement, pursuant to the terms and conditions contained in this Agreement.

H. The Company seeks to confirm in writing Advisor's agreement to provide the Company with the Consulting Services between the Effective Date and the Closing Date (unless this Agreement is sooner terminated in accordance with the provisions of Article VI below).

NOW, THEREFORE, in consideration of the premises and mutual covenants set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and for their mutual reliance, the parties agree as follows:

ARTICLE I
RECITALS; AFFILIATES

1.1 Recitals. The recitals set forth above are hereby incorporated into this Agreement as if fully set forth in this Article I.

1.2 Affiliate. As used herein, "Affiliate" means, as to GWHN or Prospect, any person or entity that directly or indirectly controls, is controlled by, or is under common control with, as applicable, GWHN or Prospect and any successors or assigns of such person or entity; and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of, as applicable, GWHN or Prospect whether through ownership of voting securities, by appointment of trustees, directors, and/or officers, by contract or otherwise.

ARTICLE II
CONSULTING SERVICES

2.1 Services. For and during the Term (as defined in ARTICLE V below) for the consideration set forth below, Advisor shall provide the Consulting Services with respect to the operation of the Hospital and other programs and services carried on by the Company (collectively, the "Business") described on Exhibit A, as it may be amended from time to time, upon the terms and conditions as set forth herein.

2.2 Delivery. The Consulting Services, as and when delivered or rendered hereunder, will be performed by personnel having the requisite skills and experience required to provide the Consulting Services on a timely basis, and will be performed in a prompt, professional and

workmanlike manner in accordance with all applicable professional standards and best practices in the industry. Advisor reserves the right to initially determine which of its personnel shall be assigned to perform Consulting Services and to replace or reassign such personnel during the term hereof. The Company, however, shall pre-approve the Advisor employees assigned to work on the Consulting Services, but such approval will not be unreasonably withheld. Advisor further agrees that, following advice received from the Company, Advisor will remove from the Consulting Services any employee or contractor to whom the Company has reasonable objection.

2.3 Maintenance of Control. The Consulting Services entail recommendations to the Company regarding how to improve the operations and financial condition of the Company's Business. The Company agrees to consent to make operational changes recommended by Advisor unless in the reasonable business judgment of the executive leadership of the Company such consent is not warranted in the circumstances. Nothing in this Agreement is intended to alter, weaken, displace or modify the authority of either (i) the Board of Trustees of the Company with respect to the ultimate oversight and governance of the Company, or (ii) the executive leadership of the Company with respect to the Business and the assets and affairs of the Company. During the Term, the Board of Trustees of the Company shall exercise ultimate authority, supervision, direction and control over the business, policies, operation and assets of the Company, and shall retain the ultimate authority and responsibility regarding the powers, duties and responsibilities vested in the Board of Trustees of the Company by any and all applicable laws and regulations. The parties mutually acknowledge and agree that any Consulting Services provided pursuant to this Agreement are intended to constitute assistance and support to the Company's Board of Trustees and executive leadership, and are not intended and shall not be construed to grant Advisor any rights or interests in, nor decision-making authority with respect to, the Company or the Business, and the rights and interests of Advisor shall be limited to those expressly set forth herein or in the Purchase Agreement, if and when executed. In furtherance of the foregoing, the Company's Chief Executive Officer shall determine the priority, timing and delivery of the projects included in the Consulting Services and may direct Advisor to redirect its efforts among such projects.

2.4 Input Into Company's Strategic Business Decisions. The Company, through its Chief Executive Officer, shall make Advisor aware of key strategic business decisions facing the Company and shall elicit input from Advisor on said decisions, and Advisor shall respond promptly, knowledgably and in the best interests of the Company.

2.5 Consulting Services Fee. In connection with its receipt of Consulting Services pursuant to this Agreement, the Company shall pay to Advisor one (1%) percent of the Company's net patient revenue, as reported in the consolidated financial statements of GWHN, per month (cumulatively, the "Consulting Services Fee"). If the Closing under the Purchase Agreement takes place, payment of the Consulting Services Fee shall be waived, and in the event the Closing does not take place, then payment of the Consulting Services Fee shall be paid in accordance with the provisions of Section 6.5 hereunder.

2.6 Company's Commitments. The Company shall provide Advisor with sufficient working space and other reasonable physical accommodations at the Facilities as appropriate to the Consulting Services, including access to telephones, facsimile machines, internet connections and copiers, to enable Advisor to fulfill its duties and responsibilities hereunder. The Company

and its management staff shall provide timely responses to Advisor's requests for information (and other inquiries) to enable Advisor to perform the Consulting Services hereunder, and shall fully cooperate with Advisor in the fulfillment of Advisor's duties hereunder, including, without limitation, attending meetings and providing information, feedback and input to Advisor.

2.7 Liaisons. Advisor shall direct all inquiries regarding the Consulting Services, and provide all recommendations, reports and other matters relating to the Consulting Services, to Darlene Stromstad, the Company's Chief Executive Officer, and/or such person(s) as she may from time to time designate. The Company shall direct all inquiries regarding the Consulting Services to Von Crockett at Prospect and/or such person(s) as he may from time to time designate.

2.8 Access of Advisor; Patient Records.

(a) During the Term, Advisor shall be given complete access to the Company's records (including Patient Records as defined below), offices and Facilities, in order that it may carry out its obligations hereunder, subject to the confidentiality requirements relating to Patient Records and Confidential Information (as defined below).

(b) The Company shall maintain, to the fullest extent of the law, sole and exclusive responsibility for the preparation, storage and destruction of all patient medical records, clinical treatment plans, charts and similar documents generated in connection with the operation of the Business (collectively, the "Patient Records"). The Company shall assure that the Patient Records are prepared in compliance with all applicable federal, state and local laws and regulations. All Patient Records will be maintained by the Company and shall remain the property of the Company.

(c) To the extent permitted by law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the standards or regulations promulgated thereunder, including the Privacy Standards and the Security Standards, as well as the federal Health Information Technology for Economic and Clinical Health Act (including any and all standards and regulations promulgated thereunder) and professional ethics regarding confidentiality and disclosure of medical information, the Company shall make such information available to Advisor to enable Advisor to perform its duties hereunder and for any and all other reasonable purposes. For the purposes of this Section 2.8, Advisor shall be referred to as the Company's Business Associate ("Business Associate"). As a Business Associate, Advisor agrees to enter into the Business Associate Agreement with the Company, attached hereto as Exhibit B.

ARTICLE III
[RESERVED]

ARTICLE IV
CONFIDENTIALITY; PROPRIETARY RIGHTS

4.1 Due to the highly competitive nature of the health care industry, disclosure of certain nonpublic, confidential or proprietary information – including but not limited to

Advisor's Proprietary Rights (as defined below), the Company's Proprietary Rights (as defined below), analyses, compilations, summaries, memoranda, studies, policy and procedure documentation information, quality assurance materials or other documents prepared by the Company or Advisor in connection with this Agreement or the Consulting Services provided hereunder (collectively, the "Confidential Information") would be extremely damaging to the party that owns or has the right to such Confidential Information. The parties therefore agree to maintain the confidentiality of the other party's Confidential Information and to protect as a trade secret any portion of the other party's Confidential Information by using reasonable efforts to prevent any unauthorized disclosure, copying, use, distribution, or transfer of possession of such Confidential Information. Each party agrees to maintain at least the same procedures regarding the other party's Confidential Information that it maintains with respect to its own Confidential Information, but in no event less than a reasonable standard of care. For purposes of this Agreement, Confidential Information shall not be deemed to include information and data: (a) rightfully previously known or acquired by either party from a third party without a continuing restriction on use; (b) that is or becomes a part of the public domain through no breach of this Agreement by either party; (c) approved for release by written authorization by the party who owns or has rights to the Confidential Information; (d) that is required to be disclosed and made public by law; or (e) independently developed by either party.

4.2 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to Advisor and its Affiliates learned, acquired or obtained by the Company and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of Advisor or its Affiliates, employed or obtained by Advisor or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which Advisor or any of its Affiliates has any interest (collectively, "Advisor's Proprietary Rights") are proprietary to Advisor and shall remain the property of Advisor or its Affiliates and are not, at any time during the Term or thereafter, to be utilized, distributed, disseminated, copied or otherwise employed or acquired by the Company, any of the Company's Affiliates, or their respective officers, directors, trustees, consultants, members, employees, shareholders, and agents, except as authorized by Advisor in writing. To the extent that such Proprietary Rights are embodied in the Consulting Services or the implementation of the recommendations of the Consulting Services, the Company shall have the perpetual, nonexclusive right to use such materials for its own operations, which rights shall survive the termination or expiration of this Agreement.

4.3 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to the Company and its Affiliates learned, acquired or obtained by Advisor and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of the Company or its Affiliates, employed or obtained by the Company or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which the Company or any of its Affiliates has any interest (collectively, "Company's Proprietary Rights") are proprietary to the Company and shall remain the property of the Company or its Affiliates and are not, at any time during the Term or thereafter, to be utilized,

distributed, disseminated, copied or otherwise employed or acquired by Advisor, any of Advisor's Affiliates, or their respective officers, directors, trustees, contractors, members, employees, shareholders, and agents, except as authorized by the Company in writing.

4.4 Each party acknowledges that the breach of the provisions of this ARTICLE IV would cause irreparable injury to the non-breaching party that could not be adequately compensated by money damages. Accordingly, the non-breaching party may obtain a restraining order, injunction or other equitable relief prohibiting a breach or threatened breach of the provisions of this ARTICLE IV without the necessity of posting any bond or security whatsoever, in addition to any other legal or equitable remedies that may be available. In the event of a breach or threatened breach by either party of any of its obligations under this ARTICLE IV, the other party shall have the right, in addition to any other remedies that may be available to it, to obtain specific performance of the terms of this Agreement without posting any security or bond whatsoever.

4.5 If requested by court order or other legal process to disclose any information constituting Confidential Information, Advisor's Proprietary Rights or Company's Proprietary Rights, the party so requested shall promptly give notice of such request or requirement to the other party so that such party may, at its own cost and expense, seek an appropriate protective order or, in the alternative, waive compliance to the extent necessary to comply with such request if a protective order is not obtained. If a protective order or waiver is granted, the party to whom the request was made may disclose such information only to the extent required by such court order or other legal process or to the extent permitted by such waiver.

4.6 The provisions of this ARTICLE IV shall survive the termination of this Agreement, provided, however, this provision shall terminate upon the Closing of the Purchase Agreement. In that event, however, the parties shall continue to be subject to the terms and conditions of that certain Confidentiality Agreement dated as of March 9, 2015, which shall remain in full force and effect in accordance with its terms.

ARTICLE V
TERM

The term of this Agreement shall commence on the Effective Date and shall continue until the Closing of the Purchase Agreement (the "Term"), unless sooner terminated in accordance with the provisions of ARTICLE VI below.

ARTICLE VI
TERMINATION

6.1 Termination by Either Party For Cause. If either party materially defaults in the performance of any material covenant, agreement, term or provision of this Agreement or the Letter of Intent to be performed by it and such material default continues for a period of thirty (30) days after written notice is delivered to the breaching party from the other party stating the specific default, then the non-breaching party may terminate this Agreement by giving written notice thereof to the breaching party; provided, however, that the non-breaching party shall not have the right to terminate under this Section 6.1 at the end of such thirty (30) day period so long

as the breaching party has commenced a cure within such thirty (30) day period and thereafter diligently pursues such cure to completion, which shall be no later than sixty (60) days after the initial written notice.

6.2 Termination Upon Bankruptcy, Etc. If either party shall apply for or consent to the appointment of a receiver, trustee or liquidator for it or for all or substantially all of its assets, file a voluntary petition in bankruptcy or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or any answer seeking reorganization or arrangement with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by a court of competent jurisdiction, on the application of a creditor, adjudicating either party to be bankrupt or appointing a receiver, trustee or liquidator of either party with respect to all or substantially all of the assets of either party, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days, then this Agreement shall automatically terminate.

6.3 Termination Upon Dissolution of the Company, Termination of Letter of Intent or Termination of Purchase Agreement. This Agreement shall terminate immediately and automatically upon the first to occur of the following events:

(a) the Company or Advisor files for voluntary dissolution;

(b) the Letter of Intent expires by its terms or is otherwise terminated; and

(c) the Purchase Agreement is terminated (in accordance with the provisions thereof) prior to a Closing of the transactions contemplated therein.

6.4 Regulatory Matters. If the performance by either party of any material covenant, agreement, term or provision of this Agreement would (a) result in the de-certification of a Hospital under any federal or state government program or by any other regulatory agency that would have a material adverse effect on the operation of the Business, (b) result in the loss of a Hospital's accreditation, or (c) be in violation of any statute or regulation, or for any other reason be or become illegal and such violation or illegality would have a material adverse effect on the operation of the Business, and in any such event, the reason therefore cannot be corrected by good faith negotiations and effort of the parties hereto within sixty (60) days after written notice thereof (with the objective of keeping the financial intent of the parties hereunder materially the same), then either party may at its option terminate this Agreement.

6.5 Certain Rights Upon Termination.

(a) In the event of any of the following:

(i) upon written notice by Advisor to GWHN, where GWHN has materially breached the exclusivity provisions of Section 14 of the Letter of Intent;

(ii) upon the receipt of the CON Approvals, if (x) Advisor has executed a purchase agreement with substantially the same economic terms as are contained in the Purchase Agreement but (y) GWHN fails to execute such purchase

agreement (without good reason) within ten (10) days after Advisor's execution thereof; or

(iii) the parties having both executed a purchase agreement with substantially the same economic terms as are contained in the Purchase Agreement, if (x) all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied by Advisor, but GWHN fails to close the transactions pursuant to Section 9.01 of the Purchase Agreement, or (y) GWHN breaches its obligations under Section 5.11(a) of the Purchase Agreement;

then, Advisor shall be paid by GWHN, within 30 days after such termination and receipt of an invoice therefor, any accrued and unpaid Consulting Service Fees. For the avoidance of doubt, in all other events, including in the event a Closing occurs under the Purchase Agreement, Advisor shall not be entitled to receive any Consulting Service Fee hereunder.

(b) The right to terminate this Agreement, and to receive payment of any amounts owing as of the effective date of termination, shall be in addition to any other remedy available pursuant to the provisions hereof. The termination of this Agreement for any reason shall be without prejudice to any payments or obligations that may have accrued or become due hereunder prior to the effective date of termination or that may become due after such termination.

6.6 Cessation of Use of Proprietary Rights Upon Termination. Upon termination of this Agreement, each party shall immediately discontinue the use of, and shall promptly return to the other party, as applicable, all Confidential Information (to the extent in tangible format) that was made available to such party by reason of its participation in this Agreement, including any copies that it may have in its possession or control.

6.7 Failure to Terminate. Failure to terminate this Agreement shall not waive any breach of this Agreement.

6.8 Survival. To the extent expressly set forth or contemplated in this Agreement, provisions of this Agreement shall survive the termination of this Agreement.

ARTICLE VII
LIABILITY, INDEMNIFICATION, PROFITABILITY AND INDEPENDENT CONTRACTOR

7.1 Limitation of Liability. Except for Advisor's gross negligence or willful misconduct, Advisor shall not by reason of this Agreement or any Consulting Services rendered pursuant to this Agreement have any liability in connection with the operation of the Business or be deemed to have assumed any liabilities associated with or incident to the operation of the Business. Without limiting the generality of the foregoing, Advisor shall have no liability for any breach of any obligation under this Agreement unless such breach shall constitute gross negligence or willful misconduct; it being understood that in such case of a breach of an obligation that does not constitute gross negligence or willful misconduct, the Company's sole remedies shall be to obtain damages pursuant to Section 15.1 below and/or to terminate this Agreement as provided herein.

7.2 Indemnification.

(a) The Company hereby agrees to defend, indemnify and hold harmless Advisor and its Affiliates, and their respective officers, directors, contractors, members, employees, shareholders, agents, successors and assigns (each, an "Advisor Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Advisor Indemnified Party arising out of or resulting from (i) any breach by the Company of any of its representations, warranties, covenants, obligations or duties under this Agreement or (ii) the Company's gross negligence or willful misconduct.

(b) Advisor hereby agrees to defend, indemnify and hold harmless the Company, and its Affiliates, and their respective officers, directors, trustees, contractors, members, employees, shareholders, agents, successors and assigns (each a "Company Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Company Indemnified Party arising out of or resulting from (i) any breach by the Advisor of any of its representations, warranties, covenants, obligations or duties under this Agreement, or (ii) Advisor's gross negligence or willful misconduct.

(c) The provisions of this Section 7.2 shall survive the termination of this Agreement.

7.3 No Representation of Profitability, Etc. Advisor does not guarantee or represent that operation of the Business will be profitable, or have a certain amount of revenues or cash flow. Except as otherwise expressly provided herein, Advisor shall not be liable for the Company's losses, whether from operation of the Business or otherwise.

7.4 Independent Contractor Status. Advisor does not under this Agreement act in any capacity other than as an independent contractor and does not, under this Agreement, act as principal in the operation of the Business, the Hospital or any other facilities of the Company.

ARTICLE VIII
NON-SOLICITATION

8.1 Covenant Not To Solicit. During the Term and for a period of two (2) years after the Term (the "Non-Solicit Period"), each party shall not, and shall cause its Affiliates not to, directly or indirectly, (a) take any action that may induce any customer, employee, agent, contractor, or vendor of the other party (either individually or in the aggregate) to discontinue his, her or its affiliation with such other party, or (b) solicit or hire the employees or independent contractors of the other party or any Affiliate thereof without the prior written consent of such other party.

8.2 Equitable Relief. In the event of a breach or threatened breach by a party or any of its Affiliates of any of the obligations under this ARTICLE VIII, the other party shall be entitled, upon application to any court of proper jurisdiction, to a temporary restraining order or

preliminary injunction to restrain and enjoin the breaching party and/or its Affiliates from such violation without prejudice as to any other remedies the non-breaching party may have at law or in equity. Each party agrees that, in the event of a violation by such party or an Affiliate thereof, it would be virtually impossible for the other party to calculate its monetary damages and that such other party would be irreparably harmed. If the non-breaching party seeks a temporary restraining order or preliminary injunction, such non-breaching party shall not be required to post any bond or other security with respect thereto, or, if, nonetheless, a bond is required, it may be posted without surety thereon. If any restriction contained in this ARTICLE VIII is held by any court to be unenforceable, or unreasonable, as to time, geographic area or business limitation, the parties agree that such provisions shall be and are hereby reformed to the maximum time, geographic area or business limitation permitted by applicable laws. The parties further agree that the remaining restrictions contained in this ARTICLE VIII shall be severable and shall remain in effect and shall be enforceable independently of each other. Each party specifically acknowledges, represents and warrants that the covenants set forth in this ARTICLE VIII are reasonable, necessary, and enforceable to protect the legitimate interests of the other party, and that such other party would not have entered into this Agreement in the absence of such covenants.

ARTICLE IX
REPRESENTATIONS AND WARRANTIES

9.1 Of Advisor. Advisor represents and warrants to the Company as follows:

(a) Advisor has been duly organized and validly exists as a corporation in good standing under the laws of the State of Delaware, with full corporate power to own its properties and to conduct its business under such laws.

(b) Advisor has the full corporate power and authority to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authorization, execution, delivery and performance of this Agreement by Advisor have been duly taken. The individual executing this Agreement on behalf of Advisor is duly authorized and has the requisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by Advisor under this Agreement, nor compliance by Advisor with any provision of this Agreement will conflict with or violate Advisor's articles of incorporation or bylaws, any agreements to which Advisor is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon Advisor's execution of this Agreement, this Agreement shall constitute a valid and binding obligation of Advisor, enforceable in accordance with its terms.

(e) Neither Advisor, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, or (iii) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

9.2 Of the Company. The Company represents and warrants to Advisor as follows:

(a) The Company has been duly organi□ed and validly exists as a nonstock corporation in good standing under the laws of the State of Connecticut, with full limited power to own its properties and to conduct its business under such laws.

(b) The Company has the full corporate power and authority as a company to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authori□ation, execution, delivery and performance of this Agreement by the Company have been duly taken. The individual executing this Agreement on behalf of the Company is duly authori□ed and has the re□uisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by the Company under this Agreement, nor compliance by the Company with any provision of this Agreement will conflict with or violate the Company□s articles of incorporation, bylaws, any agreements to which the Company is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon the Company□s execution of this Agreement, this Agreement shall constitute a valid and binding obligation of the Company, enforceable in accordance with its terms.

(e) Neither the Company nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, or (iii) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

ARTICLE X
INSURANCE

10.1 Advisor□s Re□uired Coverage. During the Term hereof, Advisor shall maintain, at its own expense, workers□compensation coverage in accordance with statutory re□uirements for Advisor□s employees who provide services under this Agreement, and commercial general liability insurance in an amount not less than One Million Dollars (□1,000,000) per occurrence and Three Million Dollars (□3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. The limits above may be satisfied by any combination of self insurance or umbrella policies, and Advisor may carry any insurance re□uired by this Agreement under a blanket policy. Company shall be an additional named insured under the Advisor□s general liability policy.

10.2 The Company□s Re□uired Coverage. The Company shall maintain, at the Company□s expense, at all times during the Term: (a) workers□compensation coverage in accordance with statutory re□uirements for the Company□s employees; (b) commercial property damage and fire□ha□ard insurance written on full replacement value basis for all of the Company□s assets and real property; (c) professional liability insurance covering the Company□s employees who perform any work, duties, or obligations against claims for bodily injury, death,

malpractice and property damage, which insurance shall provide coverage on a claims-made or occurrence basis with a per occurrence limit of not less than One Million Dollars (□1,000,000) per occurrence and Three Million Dollars (□3,000,000) in the annual aggregate; and (d) comprehensive commercial general liability insurance in an amount not less than One Million Dollars (□1,000,000) per occurrence and Three Million Dollars (□3,000,000) in the annual aggregate. The above limits may be satisfied by any combination of primary and excess or umbrella policies. The Company may carry any insurance required by this Agreement under a blanket policy. Advisor shall be an additional named insured under the Company's general liability insurance policy.

10.3 Certificates of Insurance. On the Effective Date and at any time upon request, each party shall provide the other party certificates of insurance evidencing the coverages required hereby, and shall notify the other party immediately of the cancellation, termination, or non-renewal of, or material change in, such insurance coverage.

ARTICLE XI
ARMS-LENGTH BARGAINING

The parties agree that the compensation provided herein has been determined in arm's-length bargaining and is consistent with fair market value in arm's length transactions and is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to the Hospital or other facilities of the Company or between the parties or any of the undersigned persons or equity holders thereof for which payment may be made in whole or in part under Medicare or any state health care program or under any other payor program.

ARTICLE XII
ASSIGNMENT

Neither party shall, directly or indirectly, assign or otherwise transfer this Agreement, or any interest herein or obligation hereunder, without the prior written consent of the other party, which may be withheld in such other party's sole discretion. In no event may a party assign this Agreement unless the assignee shall have executed and delivered to the other party a written assumption of this Agreement in form and substance satisfactory to such other party in its sole discretion. Notwithstanding the foregoing, Advisor shall be permitted, without the consent of the Company, to assign this Agreement to any Affiliate of Advisor, but Advisor shall remain liable to the Company for the performance and satisfaction of all undertakings and commitments set forth herein.

ARTICLE XIII
NOTICES

All notices required or permitted hereunder shall be given in writing by actual delivery or by certified mail, postage prepaid or by nationally recognized overnight courier service. Notice shall be deemed given upon delivery, or if given by mail, upon receipt or if sent by next day delivery by a nationally recognized overnight courier service, on the next business day. Notice

shall be delivered or mailed to the parties at the following addresses or at such other places as a party shall designate in writing:

If to the Company:	Greater Waterbury Health Network, Inc. 64 Robbins Street Waterbury Hospital Attn: President Fax: 203-573-6161 e-mail: dstromstad@wtbyhosp.org
with a copy (which shall not constitute notice) to:	Carmody Torrance Sandak & Hennessey, LLP 707 Summer Street, Suite 300 Stamford, CT 06901 Attn: Ann □ucker, Es□ fax: 203-252-2682 e-mail: a□ucker@carmodylaw.com
If to Advisor:	Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard, Suite 400 Los Angeles, CA 90025 Attention: Legal Department
with a copy (which shall not constitute notice) to:	Epstein Becker & Green, P.C. One Gateway Center Newark, NJ 07102 Attention: Gary W. Herschman, Es□ phone: (973) 642-1900 email: gherschman@ebglaw.com Attention: David E. Weiss, Es□ phone: (212) 351-4500 email: dweiss@ebglaw.com

ARTICLE XIV
RECORD ACCESS AND RETENTION

14.1 Access to Records. Each party hereto shall permit, and shall ensure that any subcontractor retained by it permits, the United States Department of Health and Human Services and General Accounting Office, or their authori□ed representatives, to review appropriate books and records relating to the performance hereunder to the extent re□uired under Section 1861(v)(1) of the Social Security Act, 42 U.S.C. Section 1395x(v)(1)(I), or any successor law or regulation for a period of four (4) years following the last day Advisor provided services hereunder. The access shall be provided in accordance with the provisions of Title 42, Code of Federal Regulations, Part 420, Subpart D.

14.2 Notification. Each party shall notify the other party immediately of the nature and scope of any re□uest for access to books and records described above and shall provide copies of any books, records or documents to the other party prior to the provision of same to any

governmental agent to give such other party an opportunity to lawfully oppose such production of documents. Nothing herein shall be deemed to be a waiver of any applicable privilege (such as the attorney-client privilege) by either party.

ARTICLE XV
MISCELLANEOUS

15.1 Choice of Law; Dispute Resolution; Venue.

(a) 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, without giving effect to any choice or conflict of law provision or rule thereof that would re□uire the application of any other law.

(b) Dispute Resolution. Except as provided in Section 15.2 below, in the event that any dispute, controversy or claim arises among the parties with respect to this Agreement, including as to the breach, termination or invalidity hereof (a □Dispute□), the parties shall attempt in good faith to resolve such Dispute promptly by negotiation (including at least one in-person meeting) over a period of not less than thirty (30) days, commencing upon one party□s delivery of a written notice of Dispute to the other party.

(c) Venue. In the event that any Dispute is not resolved through good faith negotiations as provided in Section 15.1(b) above, either party may submit the matter to a court of law or e□uity through the filing of a claim. The Parties agree that, except as otherwise expressly provided in Section 15.2 below, venue for any and all claims associated with a Dispute between the Parties shall rest with the state courts of the State of Connecticut.

(d) Waiver of Jury Trial. EXCEPT AS PROVIDED IN SECTION 15.2 BELOW, EACH PARTY HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM (WHETHER BASED ON CONTRACT, TORT OR OTHERWISE) ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

15.2 Injunctive Relief. Notwithstanding anything to the contrary contained herein, each party acknowledges and agrees that a party may seek, from a court of competent jurisdiction in the State of Connecticut, injunctive relief against a breaching party pursuant to Sections 4.4 and 8.2 above, without posting any bond or other undertaking.

15.3 Severability. Should any provision of this Agreement be found void or unenforceable, the remainder hereof nevertheless shall continue in full force and effect. A new provision shall be amended to this Agreement that is similar to the provision found unenforceable but which is enforceable.

15.4 Approval or Consent. Except as otherwise provided herein, whenever under any provisions of this Agreement, the approval or consent of either party is re□uired, such approval or consent shall not be unreasonably withheld, conditioned or delayed.

15.5 Entire Agreement. This Agreement contains the entire agreement between the parties with respect to the subject matter hereof, and the parties expressly agree that this Agreement supersedes and rescinds any prior agreement between them (verbal or written) pertaining to the subject matter hereof.

15.6 No Third Party Beneficiary. Except as expressly provided in this Agreement, no person or entity that is not a party to this Agreement shall be a third party beneficiary of any rights or obligations hereunder or be entitled to enforce any of said rights or obligations.

15.7 Interpretation. The article and paragraph headings contained herein are for convenience of reference only, do not constitute part of this Agreement, and are not intended to define, limit or describe the scope of intent of any provision of this Agreement. All gender references used in this Agreement shall include all genders, and the singular shall include the plural and the plural shall include the singular whenever and as often as may be appropriate.

15.8 Force Majeure. Neither Company nor Advisor shall be deemed to be in violation of this Agreement, and shall not be liable for any resulting claims, losses, damages, expenses and liabilities if it is prevented, hindered or delayed, either directly or indirectly, from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation labor disputes, fires, storms, earthquakes, acts of God, or any statute, regulation or rule of the federal government, any state or local government or any agency thereof.

15.9 Amendments; Course of Dealing. This Agreement may be amended or supplemented only in a writing signed by both parties. The failure of any party to enforce at any time any of the provisions of this Agreement shall in no way be construed to be a waiver of any such provision, nor in any way to affect the validity of this Agreement or any part hereof or the right of any party thereafter to enforce each and every such provision. No waiver of any breach of this Agreement shall be held to be a waiver of any other or subsequent breach.

15.10 Cooperation; Further Assistance. From time to time, as and when reasonably requested by either party hereto, the other party will (at the expense of the requesting party) execute and deliver, or cause to be executed or delivered, all such documents, instruments and consents and will use reasonable efforts to take all such action as may be reasonably requested or necessary to carry out the intent and purpose of this Agreement.

15.11 Execution of this Agreement. The parties may execute this Agreement in counterparts, each of which shall be deemed an original and both of which together shall constitute but one and the same instrument. A signature delivered by facsimile or PDF shall be sufficient for all purposes between the parties.

[*signature page follows*]

IN WITNESS WHEREOF, the parties have executed this Agreement, through their duly authorized representatives, effective as of the date first above written.

ADVISOR:

PROSPECT MEDICAL HOLDINGS, INC., a Delaware corporation

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

THE COMPANY:

GREATER WATERBURY HEALTH NETWORK, INC., a Connecticut non-stock corporation

By:_____
Name: Darlene Stromstad
Title: President

[Signature Page to Interim Consulting Agreement]

IN WITNESS WHEREOF, the parties have executed this Agreement, through their duly authorized representatives, effective as of the date first above written.

ADVISOR:

PROSPECT MEDICAL HOLDINGS, INC., a Delaware corporation

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

THE COMPANY:

GREATER WATERBURY HEALTH NETWORK, INC., a Connecticut non-stock corporation

By:_____
Name: Darlene Stromstad
Title: President

[Signature Page to Interim Consulting Agreement]

EXHIBIT A
LIST OF CONSULTING SERVICES

In consideration of the payments to be made hereunder, Advisor shall from time to time and as appropriate provide, either directly or indirectly through one or more of its Affiliates, the following services to the Company:

1. Advise the Company regarding trends in the industry, make recommendations regarding new and/or expanded services and programs, physician alignment & recruitment, IT/EMR capabilities and improvements, technology implementation, ACOs and other reform-driven approaches, and managed care approaches.

2. Review, assess and provide recommendations regarding potential service consolidation and restructurings to achieve efficiencies.

3. Review, assess and provide recommendations regarding new clinical service lines, programs and locations.

4. Review, assess and provide recommendations regarding physician-alignment strategies, joint ventures and other strategic initiatives.

5. Advise the Company regarding expenditure and spending patterns, evaluate standard procurement lifecycle methodologies including working cash vs. discount modeling, invoice synchronization and vendor payment management. Such expenditures and contracts would include without limitation:

    - Third party service providers
    - Supply contracts
    - Contracts with outside contractors or consultants
    - Preventive maintenance with respect to equipment and building
    - Upkeep and maintenance of the physical facilities

6. Advise the Company regarding third- party reimbursement issues and consultation on such issues and compliance with all applicable reimbursement rules.

7. Assist the Company to develop, implement and maintain a compliance program that is committed to promoting, preventing, detecting and resolving instances of conduct that do not conform to federal or state laws.

8. Assist the Company to develop plans with respect to labor relations matters.

9. Review, assess and provide recommendations regarding a physician-led and focused clinical documentation program.

10. Review, assess and provide recommendations regarding the Company s case management program and length of stay initiatives.

11. Assist the Company to develop strategies with respect to cost accounting processes.

12. Provide other Consulting Services as mutually agreed upon in writing by the parties from time to time.

EXHIBIT B
BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into as of the last date of signature (the "Effective Date") by and between Greater Waterbury Health Network, Inc., by and on behalf of its covered entity subsidiaries, affiliates and related organizations (collectively, "Covered Entity"), and Prospect Medical Holdings, Inc., by and on behalf of its business associate subsidiaries, affiliates and related organizations (collectively, the "Business Associate").

R E C I T A L S

Covered Entity and Business Associate have entered into a signed Interim Consulting Agreement and/or other documented arrangement (collectively, the "Consulting Agreement") pursuant to which Business Associate provides services to Covered Entity ("Services") that may require Business Associate to access, create and use health information that is protected by state and/or federal law; and

WHEREAS, the Business Associate is obligated to protect the privacy and security of individually identifiable health information ("Protected Health Information" or "PHI") and electronic protected health information ("EPHI") created and/or maintained by Covered Entity in accordance with the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations at 45 C.F.R. Parts 160 and 164 promulgated by the U.S. Department of Health and Human Services ("HHS"), as amended by the federal Health Information Technology for Economic and Clinical Health Act ("HITECH Act") and its implementing regulations (collectively "HIPAA"); and

WHEREAS, Covered Entity and Business Associate desire to enter into this Agreement in order to comply with HIPAA, as may be modified or amended, including future issuance of regulations and guidance by HHS, and reflect their understanding of the use, disclosure and general confidentiality obligations of Business Associate as it relates to the Consulting Agreement.

NOW, THEREFORE, in consideration of the mutual promises and other consideration contained in this Agreement, the parties agree as follows:

ARTICLE I
DEFINITIONS

Capitalized terms used herein but not otherwise defined in this Agreement shall have the same meanings as set forth in HIPAA, as may be modified or amended, including future issuance of regulations and guidance by HHS.

ARTICLE II
OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

2.1 Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as permitted or required by law.

2.2 Business Associate may use and disclose PHI for the proper management and administration of Business Associate; provided that with respect to any disclosures of PHI, such disclosures are required by law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person. Business Associate may, in accordance with the Privacy Rule, de-identify PHI. Without limitation of the foregoing, Covered Entity acknowledges that the legal structure of the Business Associate and its affiliates, including Prospect Medical Holdings, Inc., affords the Business Associate the opportunity to be characterized for HIPAA purposes as a participant in an affiliated covered entity arrangement as part of such legal structure ("HIPAA Arrangement"), and as such Covered Entity agrees that disclosure of PHI may be made to the other participants in such HIPAA Arrangement and that such other participants in such HIPAA Arrangement may use or disclose PHI, only in compliance with the terms of this Agreement.

2.3 Business Associate agrees to use appropriate physical and technical safeguards to prevent the use or disclosure of Covered Entity's PHI for any purpose other than the provision of Services under this Agreement.

2.4 Upon written request from the Covered Entity, Business Associate agrees to report to Covered Entity, in writing, any use or disclosure of PHI not in compliance with this Agreement.

2.5 In the event Business Associate engages any agent or subcontractor to perform the services under this Agreement and discloses PHI to such agent or subcontractor, Business Associate will require any such agent or subcontractor to agree to the same restrictions and conditions required in this Agreement.

2.6 Upon written request from the Covered Entity, Business Associate agrees to make PHI available to individuals in accordance with 45 CFR Section 164.524 of HIPAA governing access of individuals to PHI.

2.7 Upon written request from the Covered Entity, Business Associate agrees to make PHI available for amendment and incorporate any amendments in accordance with 45 CFR Section 164.526 of HIPAA governing amendments to PHI.

2.8 Upon written request from the Covered Entity, Business Associate agrees to make any and all information available for the purpose of providing patients an accounting of disclosures in accordance with 45 CFR Section 164.528 of HIPAA governing accounting for disclosures.

2.9 Business Associate agrees to make its internal practices, books and records related to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity, available to the Secretary of HHS and the HHS Office for Civil Rights for the purposes of determining Covered Entity's compliance with HIPAA.

2.10 Business Associate shall implement and maintain safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains or transmits on behalf of Covered Entity.

2.11 Business Associate and Covered Entity agree to comply with all applicable rules and regulations promulgated under HIPAA in effect during the term of this Agreement.

2.12 Business Associate will report to Covered Entity within a reasonable time period of discovery, any (a) Security Incident, or (b) Security Breach as defined at 45 C.F.R. Part 164, Subpart D. Business Associate may supplement its initial report as information becomes available in order to identify:

(a) The nature of the non-permitted use or disclosure including how such use or disclosure was made;

(b) The unsecured PHI used or disclosed;

(c) If possible and applicable, the identity of the person/entity who received the unsecured PHI;

(d) What corrective action Business Associate took;

(e) What Business Associate did to mitigate any deleterious effect; and

(f) Such other information as Covered Entity may request.

2.13 At all times during the term of this Agreement, Business Associate will comply with all applicable federal, state and local laws, rules and regulations applicable to business associates and pertaining to patient records and the confidentiality of patient information, including Covered Entity's PHI.

ARTICLE III
OBLIGATIONS OF COVERED ENTITY

3.1 Covered Entity will notify Business Associate of any agreement Covered Entity makes regarding any restriction or requirement for confidential communication with respect to the use or disclosure of PHI, to the extent that such restriction agreement or confidential communication requirement may affect Business Associate's use or disclosure of PHI.

3.2 Covered Entity will: (i) use safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Business Associate, until such PHI is received by

Business Associate; and (ii) inform Business Associate of any consent or authorization, including any changes in or withdrawal of any such consent or authorization, provided to the Covered Entity by an individual.

ARTICLE IV
TERM AND TERMINATION

4.1 This Agreement shall remain in effect until such time as the Consulting Agreement expires or is terminated.

(a) Except for the requirements set forth in Section 4.2, which shall survive as set forth therein, and except as otherwise provided in Section 4.1(b), this Agreement will terminate on the date that the Consulting Agreement is terminated or expires.

(b) This Agreement may be terminated by Covered Entity upon the breach of any material provision of this Agreement by Business Associate, which breach is not corrected within thirty (30) days after written notice of such breach is given to Business Associate. If cure of the breach and termination of this Agreement is not feasible, Covered Entity may report the breach to HHS as required by law.

4.2 Business Associate agrees that, upon termination of the Consulting Agreement and this Agreement, Business Associate will return or destroy all PHI received from or created or received on behalf of Covered Entity. In the event Business Associate determines that return or destruction is not feasible, Business Associate will extend the protections required in this Agreement to the PHI and limit further uses and disclosures to only those purposes that make the return or destruction of the information infeasible.

ARTICLE V
MISCELLANEOUS

5.1 Regulatory References. A reference to HIPAA or the HITECH Act, or a section thereof, and its regulations and requirements means the provisions and section(s) in effect, as may be modified or amended, including issuance of regulations and guidance by HHS.

5.2 Amendment. Both parties agree that the provisions of HIPAA and the HITECH Act, including provisions which apply to business associates and that are required to be incorporated into a HIPAA business associate agreement, are hereby incorporated into this Agreement as if set forth in this Agreement in their entirety and are effective as of the Effective Date. Notwithstanding the foregoing, the parties agree to take such action as is required by law to amend this Agreement pursuant to additional regulations or amendment of HIPAA and the HITECH Act.

5.3 Notices. Any notices to be delivered hereunder shall be delivered to the addresses set forth in and consistent with the requirements for delivery contained in, the Consulting Agreement. Notice shall be in writing and shall be deemed effective when personally delivered

or, if mailed, three (3) calendar days after the date deposited in the United States mail, first class, postage prepaid, to the addressee at its current business address.

5.4 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original and when taken together shall constitute one agreement.

5.5 Choice of Law. All issues and □uestions concerning the validity, enforcement and interpretation of this Agreement shall be governed by, and construed in accordance with, the laws of the state identified in the Consulting Agreement.

5.6 Voluntary Execution. Each party has read and understands this Agreement, and represents that this Agreement is executed voluntarily and should not be construed against any party hereto solely because it drafted all or a portion hereof.

5.7 Severability. If any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability will not affect any other provision and this Agreement will be reformed, construed, and enforced as if such invalid, illegal or unenforceable provision had never been contained herein.

5.8 No Modification. No modification of this Agreement will be effective unless made in writing and executed by each party hereto, except as otherwise provided hereunder.

5.9 Entire Agreement. This Agreement supersedes any and all prior agreements and understandings between the parties related to the subject matter hereof.

5.10 Independent Contractor. None of the provisions of this Agreement are intended to create any relationship between the parties other than that of independent entities contracting with each other for the purpose of effecting the provisions of this Agreement.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Agreement to be executed and delivered as of the day and year first above written.

COVERED ENTITY:	BUSINESS ASSOCIATE:
GREATER WATERBURY HEALTH NETWORK, INC.	PROSPECT MEDICAL HOLDINGS, INC.
BY: _____	BY: _____
NAME: Darlene Frantad	NAME: _____
ITS: Pres / CEO	ITS: _____
DATE 10/27/17	DATE: _____

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Agreement to be executed and delivered as of the day and year first above written.

COVERED ENTITY:	BUSINESS ASSOCIATE:
GREATER WATERBURY HEALTH NETWORK, INC.	PROSPECT MEDICAL HOLDINGS, INC.
BY: _____	BY: _____
NAME: _____	NAME: Sam Lee
ITS: _____	ITS: CEO
DATE _____	DATE: 10/27/15

EXHIBIT Q5-1

OFFICE OF HEALTH CARE ACCESS SPECIAL STUDY DN 06-30760-VST

Wtby Hosp
County Hosp

Office of Health Care Access

Report of Investigative Proceedings

Docket Number 06-30760-VST

May 23, 2007

Cristine A. Vogel
Commissioner
Office of Health Care Access

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D. Hospital Closures and Mergers in Connecticut

E. Report of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Group

I. Executive Summary

The health care services provided in the Waterbury area appear to be fragmented, competitive and in financial distress. Although utilization of inpatient and outpatient services is high -- profit margins remain low at both St. Mary's Hospital and the Waterbury Hospital. Access to care is not yet impacted; however, the long-term viability of the health care delivery system is at risk -- presenting an opportunity to restructure and develop an efficient and responsive health care delivery system. After an extensive review of data in this investigation, some of the findings are:

- Saint Mary's Hospital's financial measures indicate that the hospital is insolvent.
- Data suggest that the financial viability of the health system is more sustainable with one hospital and one outpatient system of care.
- Duplication of services is competitive and costly and limits profitability.
- A merger of St. Mary's Hospital and Waterbury Hospital is an option; however, many major issues exist.
- A planned closure of St. Mary's Hospital may be a viable solution providing a pre-determined integration plan is in place.
- Utilization data demonstrate a consistent and steady demand for inpatient and outpatient services will continue in the community.
- A comprehensive primary care system needs to be developed to respond to the immediate need for access which will ultimately improve the hospitals' financial viability and the health status of the community. Data suggest a lack of primary care services exists forcing individuals to utilize the Emergency Department as their health care provider.
- Behavioral health services must be expanded in a comprehensive and cohesive manner.

The financial hardship that St. Mary's Hospital (SMH) and the Waterbury Hospital (WH) struggle with is mostly a result of an economically challenged city. Waterbury experiences a higher rate of uninsured and unemployed compared to the state as a whole and has a lower per capita income. Socioeconomics and demographics play a significant role in the financial condition of hospitals since they rely on philanthropic donations and the balance of government and non-government reimbursement to offset losses.

Additionally, financial hardship can be created when two hospitals are located in close proximity to each other. The expenses related to marketing, advertising, recruitment and retention are increased as each hospital is competing for the most qualified employees and the most profitable patients. Related to the expenses of competition – is duplication. The duplication that exists in the outpatient market results in the thinning out of profitable services so neither organization can leverage the profit. These costs are in addition to those targeted at competing hospitals located in the secondary market. Also

related to competition is the lack of negotiating power the hospitals face during the contracting phase with managed care organizations. Typically the commercial discounts are greater in an area served by two hospitals which decreases the reimbursement from the most lucrative payer source.

This investigation conducted by the Office of Health Care Access (OHCA) was initiated to assess the viability of the health care delivery system in the Waterbury area. Several state agencies have been periodically meeting and discussing the information that OHCA has been collecting. The other state agencies involved are: Department of Public Health (DPH), Department of Social Services (DSS), Office of Policy and Management (OPM), and the Connecticut Health and Educational Facilities Authority (CHEFA).

The purpose of this investigation was to study the socioeconomic factors, utilization of hospitals services and a review of the financial condition of SMH and WH and the impact these factors have on ensuring sustainable access to hospital care in the Waterbury area. Both hospitals have reported negative operating margins for the past two years and have not experienced a strong fiscal year in some time. For Fiscal Year 2006, SMH reported a Total Margin of 0.4% and an Operating Margin of (3.7)%; and WH reported a Total Margin of (2.4)% and an Operating Margin of (3.7)%.

The distressed financial condition of both hospitals, although more severe with SMH, has restricted access to capital for facilities improvement and renovation projects. Both of the hospitals' facilities are aging, they lack sufficient parking, and increasing the capacity to meet demand for services in the Emergency Departments and patient floors has become cost-prohibitive. Thus, occupancy rates are high in many service lines and yet beds, although within licensed bed count, cannot be added.

According to FY06 audited financial statements, St. Mary's Hospital has enough cash to pay one (1) day of its short-term commitments and is taking longer than normal to pay its creditors. Although Waterbury Hospital has more cash on hand and is paying its creditors earlier than prior years, both hospitals are exhibiting the classic symptoms of financial distress.

Each of the findings mentioned above will be further discussed in the Discussion and Conclusions section of this report. All data used in this report can be found in the Findings of Fact section and the Attachments.

II. Summary of Findings

This investigation thoroughly reviewed the socio-economic characteristics, the utilization of services, and the financial challenges of St. Mary's Hospital and the Waterbury Hospital. A detailed analysis of these factors is contained in Attachment A of this report. This summary is provided as an overview of the key factors that contribute to the on-going financial losses of the hospitals.

Socio-economic Characteristics:

Although there are seven towns that best define the "Waterbury Area" included in the investigation, a significant portion of residents who rely on and access St. Mary's Hospital and the Waterbury Hospital for health care services live in the towns of Waterbury, Naugatuck or Watertown. This area consists mostly of:

- young adults who may be full-time students, single, unemployed or have no permanent full-time jobs and therefore, likely to be uninsured;
- a disproportionate share of residents who are over 75 years old and live in the city of Waterbury who maybe inclined to suffer from chronic diseases that need management;
- minorities that have high hospitalization and uninsured rates;
- residents who are less likely to have a college degree or higher, to be skilled professionals or employed;
- a labor force that has a comparably higher tendency to work in service, production, transportation and material moving industries that are seasonal, temporary or part-time in nature;
- people who earn less than the statewide average per capita or household income;
- a population that has a high incidence of hospitalizations that could have been prevented if residents had adequate access to community health services; and
- a federally medically and primary care underserved population.

Utilization:

Utilization data collected in this investigation demonstrated an active use of inpatient and outpatient health care services. There was no significant decline in utilization which in other circumstances would be a reason for a deterioration of financial stability – the Waterbury hospitals show steady volume. This data is summarized for FY 2006 for SMH and WH combined:

- 27,562 Inpatient discharges (remained steady for the past 3 years)
- 116,644 Emergency Department visits (slight increase over the past 3 years)
- 91,684 Medical and Behavioral Health Clinic visits (overall no increase)
- 245,638 Other "outpatient" visits (i.e., surgery, radiology, etc.)

Fundamental system issues exist so although there is steady utilization of services, it is difficult to assess the necessary "size" of the health care system. The Emergency Departments show a higher utilization than typical - probably related to the lack of alternatives available; and each hospital stated the difficulty of discharging certain patients due to an inability to transfer patients to the next level of care.

Combined, the hospital system in the Waterbury area has 704 inpatient beds and 68 bassinets. Over a three-year period, the two hospitals gradually increased the number of staffed beds to 447 or 62% of licensed beds and 68 bassinets. Most of the beds (72% or 323) are for medical/surgical and critical care, 62 beds are for OB/GYN care, 42 beds for psychiatry and 36 beds for pediatric care. Based on the demographic profile of the area, there is excess demand for medical/surgical, critical care and psychiatric beds and insufficient demand for OB/GYN and pediatric beds. Although the high demand have resulted in rather high average occupancy rates (approximately 80%) over the year, the two hospitals have been limited in how many additional beds they can staff because of space constraints, capital costs, staffing shortages or difficulty with discharging patients to the appropriate level of care to a different facility (i.e., skilled nursing, rehabilitation).

Medical care is about one-half of the inpatient care the hospitals provide, surgical and maternity/pediatric care make up one-quarter each and behavioral health care is 5%. While over the three-year period the number of patients discharged increased by only 1%, patient days grew by 5%. With the increases in volumes, the cost of providing care per discharge in the area rose by 20% but growth in revenue did not keep pace with the cost as would be expected, rather loss per discharge more than doubled. Although both hospitals were incurring losses in all inpatient care service lines, larger losses were associated with behavioral health and surgical care. In FY 2006, the loss per discharge (both hospitals combined) in each service line was $2,834 for behavioral health, $1,871 for surgical care, $794 for maternity/pediatrics care and $127 medical care. But loss per service line per discharge varied between the two hospitals, the losses for medical, behavioral health and maternity/pediatric care were lower at St. Mary's Hospital, while the loss per discharge associated with surgical care was lower at Waterbury Hospital. However, some of the differences are explained by what each hospital includes in its components of costs.

The two hospitals combined have 73 Emergency Department (ED) beds and both experience the "boarding" of patients that require admission to an inpatient unit. The hospitals state that staffing, space constraints, and the lack of access to capital constrain their ability to improve through-put of patients in their respective EDs. Approximately 14% of ED visits in the area result in an inpatient admission and like the state and nation account for about one-half of all discharges. As in the case of inpatient services, both hospitals provide ED services at a loss per case.

In the area of medical and dental outpatient care, an affiliate of St. Mary's Hospital provides these services at a loss per visit despite high volumes. An affiliate of Waterbury Hospital provides some outpatient and HIV treatment services and records high volumes but was unable to provide cost data for evaluation. Affiliates of both hospitals also provide outpatient behavioral health clinic services; however, the Waterbury Hospital provides 90% of these services. Loss per visit is almost the same for both facilities, but visits per case to the St. Mary's Hospital behavioral health clinic are three times the visits made to the Waterbury Hospital clinic.

Other outpatient services such as one-day surgery, radiology/imaging, laboratory, gastroenterology and other services are the most profitable services both hospitals provide although the cost at Waterbury Hospital is 1.5 times the cost at St. Mary's Hospital.

The financial instability of both hospitals is not a result of low utilization. The hospitals' combined inpatient discharges for FY06 are 27,562; however, on average the hospitals combined lose $899 per case. In surgical cases, typically a profitable service, the combined hospital loss per case is $1,871. The utilization of the emergency departments is higher than that of the state average which is indicative of a lack of alternative primary health care services. In FY06, the two hospitals reported 116,644 visits to their EDs. This presents a fiscal challenge when 42% of their patients are covered by Medicaid and 10% are uninsured. Of the patients that were treated and discharged (not admitted) from the ED, the hospitals lose a combined $28 per case. This amount of loss per case for such a large volume is difficult to offset since they realize losses in their inpatient services and they have a relatively low reimbursement rate from commercial payers.

Hospital Payer Mix:

When all services are combined (inpatient and outpatient) for both hospitals, commercial payers are the dominant primary payer in the Waterbury Area accounting for 41% of total patient volume. Medicare accounts for 30%, Medicaid for 23% and the uninsured for 4% (Table 1). In fact, commercial payers are the leading primary payer (46%) in the sole profitable areas of service for the hospitals in the "other outpatient services" category, which include medical clinics, one-day surgery, radiology, laboratory, gastroenterology and all other services except ED and outpatient psychiatry. The payer mix varies between services and hospitals. EDs in the area have an unfavorable payer mix with over one-half of their patient volume being either Medicaid-covered or uninsured and an annually declining share of commercially-covered patients. Although both hospitals provide care to a large portion of uninsured patients (9% for St. Mary's Hospital and 11% for Waterbury Hospital), St. Mary's Hospital treats a disproportionate share (49%) of Medicaid patients in the ED. The payer mix presented in Table 1 is highly correlated to the demographic profile outlined in Section 3.0 of Attachment A.

Table 1: Waterbury Area Hospitals Payer Mix by Department, FYs 2004 - 2006

Services	Primary Payer	St. Mary's (2)			Waterbury (2)			Waterbury Area Hospitals (2)		
		FY06	FY05	FY04	FY06	FY05	FY04	FY06	FY05	FY04
Inpatient Discharges	Medicare	42	43	43	44	43	43	43	43	43
	Medicaid	25	23	23	21	20	20	23	22	21
	Commercial	31	32	32	33	34	34	32	33	33
	Worker's Compensation	1	1	1	1	1	1	1	1	1
	Self-pay/uninsured	1	1	1	1	2	1	1	1	1
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Emergency Department Treated and Discharged Visits	Medicare	14	15	15	17	18	18	15	16	16
	Medicaid	49	46	43	34	33	32	42	40	38
	Commercial	26	27	29	36	37	37	30	32	33
	Worker's Compensation	2	2	3	3	3	3	2	3	3
	Self-pay/uninsured	9	9	10	11	10	10	10	10	10
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Outpatient Behavioral Health Visits	Medicare	9	13	9	46	47	45	43	44	42
	Medicaid	55	58	54	37	35	38	38	37	39
	Commercial	36	28	36	15	16	16	17	17	17
	Worker's Compensation	0	0	0	0	0	0	0	0	0
	Self-pay/uninsured	1	1	0	2	2	2	2	2%	2
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
All Other Outpatient Visits	Medicare	32	33	32	30	31	32	31	32	32
	Medicaid	17	17	16	18	18	18	18	18	17
	Commercial	47	47	46	45	45	45	46	46	45
	Worker's Compensation	1	1	3	1	1	1	1	1	2
	Self-pay/uninsured	2	2	3	5	5	4	4	3	4
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Total	**Medicare**	**28**	**28**	**28**	**32**	**33**	**33**	**30**	**31**	**31**
	Medicaid	**26**	**26**	**24**	**20**	**19**	**19**	**23**	**23**	**22**
	Commercial	**41**	**41**	**41**	**42**	**42**	**42**	**41**	**42**	**41**
	Worker's Compensation	**2**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	**2**
	Self-pay/uninsured	**4**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	**4**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Financial Indicators:

There is no single financial measure that, by itself, indicates the financial health of or the financial difficulty faced by a hospital. Important indicators to consider are the utilization of services, the payer mix, reimbursement, profit/loss of services, the ability the hospital has to meet its short-term obligations and its access to capital in order to continue to improve facilities and equipment. For consecutive years, both hospitals experienced negative operating margins, also a signal of financial distress.

St. Mary's Hospital's financial performance has deteriorated in the past three (3) years its low current assets to current liabilities ratio, 0.8 in FY06, put the hospital at a higher risk for technical insolvency (below 10th percentile). To improve cash flow, the hospital

shortened the average time it took to collect revenues from billed patients by ten days down to 38 days but that was not enough to improve the average time it took to pay creditors, that increased by a day to 72 days (Table 2).

Waterbury Hospital has experienced deterioration in its cash flows as well. The hospital's days of cash on hand have reduced from 42 days to 20 days, which is below state and national medians. It took the hospital seven days more to collect revenues from billed patients on average, but it paid its creditors five days earlier than it did the year before. Waterbury Hospital is at very low risk of technical insolvency since its current assets to current liabilities ratio in FY06 was 2.03 which is above the median for the state and nation (Table 2).

A serious concern for both hospitals is the difficulties they will have in financing future debt for capital projects. In order for any hospital to maintain standards of care and to remain competitive, they need to be able to invest in aging facilities, upgrade to advanced technologies, and expand or renovate to meet patient demands.

Table 2. Financial Indicators of St. Mary's Hospital and Waterbury Hospital (FY 2004 – 2006)

Financial Statistics	St. Mary's Hospital*			Waterbury Hospital		
	2006	2005	2004	2006	2005	2004
Net Assets						
Hospital	($136,000)	$23,760,000	$26,430,000	$124,628,134	$126,535,925	$119,504,105
Health System	$1,424,000	$8,469,000	$16,197,000	$163,330,870	$166,079,218	$158,400,874
Financial Indicators						
Current ratio	0.8	1.96	1.78	2.03	2.15	1.93
Days of expenses in accounts payable	72	71	69	42	47	56
Days cash on hand	1	3	5	20	34	42
Days of revenue in accounts receivable	38	48	60	49	42	37

Source: *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2005, the hospitals' Audited Financial Statements &*data submitted by the hospitals in response to the investigation.*

Current Ratio: the Current Ratio is the most widely used measure of liquidity. The value of the Current Ratio measures the number of dollars held in current assets per dollar of current liabilities. From an evaluation perspective, high values for the Current Ratio imply a good ability to pay short term obligations and thus a low probability of technical insolvency. Nationally, Current Ratios fluctuate around 2.0.

System of Care

The infrastructure that provides access to outpatient primary care and behavioral health services overall appears to be fragmented and at capacity. The lack of access to primary health care is demonstrated by the high utilization of emergency departments and the high incidence of hospitalizations that could have been prevented if residents had adequate access to preventive community services (Attachment A). The clinics that each

hospital operates and the Federally Qualified Health Center in Waterbury also appear to be at capacity. Additionally, there is a serious concern with the ability for clinic patients to access specialty care since the majority of physicians do not accept many Medicaid patients.

In continued research regarding access to pediatric inpatient psychiatric services (Attachment E), it was recommended that Region 5 (Waterbury being part of) expand inpatient beds as well as develop a Psychiatric Residential Treatment Facility (PRTF). The lack of availability of different levels of care is creating long delays to transfer behavioral health patients to other providers and typically those referrals are out of the region.

Office of Health Care Access

Report of Investigative Proceedings

Subject Title:	**An Investigation to review utilization and capacity of acute care general hospital services provided in the "Waterbury Area"**
Docket Number:	**06-3070-VST**
Statutory Reference:	**Section 19a-633 of the Connecticut General Statutes**
Proceeding Date:	**December 19, 2006**
Presiding Officer:	**Cristine A. Vogel**
Date of OHCA Report:	**May 23, 2007**

Cristine A. Vogel
Commissioner
Office of Health Care Access

Findings of Fact

1. Saint Mary's Hospital ("SMH") is an acute care hospital located at 56 Franklin, Waterbury, Connecticut. SMH's total license capacity is 379 beds and bassinets.

2. Waterbury Hospital ("WH") is an acute care hospital located at 64 Robbins Street in Waterbury, Connecticut. WH's total licensed bed capacity is 393 beds and bassinets.

3. On May 25, 2006, the Office of Health Care Access (OHCA) pursuant to Connecticut General Statutes (C.G.S.) Section 19a-633 initiated an investigation to review utilization and capacity of acute care general hospital services provided in the "Waterbury Area." The general acute care hospitals located in the city of Waterbury are St. Mary's Hospital and The Waterbury Hospital.

4. **Table 1: Financial Performance of St. Mary's and Waterbury Hospitals (FYs 2004 – 2006)**

Financial Indicators	St. Mary's Hospital			Waterbury Hospital		
	FY 2004	FY 2005	FY 2006	FY 2004	FY 2005	FY 2006
Operating Loss/Gain[1]	$6,306,000	$(15,270,000)	$(6,393,000)	$(448,506)	$(2,431,845)	$(8,069,534)
Excess of Revenue over Expenses[2]	$11,480,000	$(6,581,000)	$744,000	$2,275,334	$(30,448)	$(5,303,186)
Operating Margin[3]	4.2%	(10.02)%	(3.7)%	(0.2)%	(1.2)%	(3.7)%
Total Margin[4]	7.68%	(4.3)%	0.44%	1.2%	(0.01)%	(2.4)%

Source: *Audited Financial Statements.*

[1] Loss or gain from reimbursement of patient services from government and non-government payers.

[2] Difference between revenue obtained from direct patient care and funds from other sources and expenses.

[3] Measures profitability and is the ratio of loss or gain per unit total operating revenue.

[4] Measures profitability and is the ratio of total operating and non-operating revenue loss or surplus to total operating revenue.

5. The investigation reviews current availability and utilization of, and demand for hospital services, system capacity and the challenges these two hospitals face in meeting demands from the community they serve. This involves an evaluation of:
   - the socio-economic make-up of the community that relies on services of the hospitals, implications on the hospitals' patient payer-mix and the effect of reimbursements on hospital operations and future plans;
   - current utilization and future demand for all hospital services including inpatient, emergency department, primary care clinics, outpatient psychiatric care and ancillary outpatient services in the area; and
   - challenges that exist in the market in general and their impact on the hospitals' operations.

6. OHCA determined that the following seven towns most frequently access health care services at "SMH" and "WH": Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown and Wolcott.

Table 2: Other Connecticut hospitals' percentage share of discharges originating from the seven selected towns, FYs 2003-2005

Acute Care Hospital	Middlebury %	Naugatuck %	Prospect %	Southbury %	Waterbury %	Watertown %	Wolcott %	% of Hospital Total
St. Mary's	**21.5**	**32.5**	**35.7**	**7.7**	**44.6**	**20.3**	**41.2**	**81.2**
Waterbury	**53.5**	**41.2**	**37.4**	**34.9**	**42.4**	**62.7**	**30.7**	**86.5**
Bridgeport	2.0	3.1	2.6	2.1	1.4	2.1	1.6	2.6
Danbury	5.7	2.1	0.5	38.9	1.1	1.9	0.5	6.8
John Dempsey	0.8	0.8	1.1	0.7	0.8	0.7	1.9	2.7
Griffin	1.1	5.9	1.4	1.7	0.5	0.4	0.3	5.2
St. Raphael's	2.8	2.5	4.8	1.8	1.5	1.4	2.6	2.1
Yale	6.8	5.9	8.7	6.2	3.6	4.7	4.2	2.8
Other*	5.7	6.0	7.8	6.0	4.3	5.8	17.1	0.6
Total (%)	**100**	**100**	**100**	**94**	**100**	**100**	**100**	
# of Discharges	**2,062**	**11,365**	**3,144**	**7,413**	**49,156**	**7,349**	**5,395**	

Source: *Office of Health Care Access Acute Care Discharge Database*
*Includes the other 23 hospitals, which individually did not discharge a significant share of patients from the seven towns.

7. According to Census 2000 data, approximately 208,861 residents live in the "Waterbury Area" as defined in Fact 6.

8. A significant portion of residents who rely on services provided by SMH and WH live in Waterbury, Naugatuck or Watertown and the socio-economics of this population is described as follows:

- young adults who may be full-time students, single, unemployed or have no permanent full-time jobs and therefore likely to be uninsured;
- a disproportionate share of residents who are over 75 years old live in the city of Waterbury who maybe inclined to suffer from chronic diseases that need management.
- minorities that have high hospitalization and uninsured rates;
- residents less likely to have a college degree or higher, to be skilled professionals or employed;
- a labor force that has a comparably higher tendency to work in service, production, transportation and material moving industries that are seasonal, temporary or part-time in nature;
- people who earn less than the statewide average per capita or household income;
- a population that has a high incidence of hospitalizations that could have been prevented if residents had adequate access to community health services; and
- a federally medically and primary care underserved population.

9. In November 2005, the Primary Care Office of the Connecticut Department of Public Health designated the city of Waterbury as a medically and a primary care underserved area under federal laws.

10.

Table 3: Licensed and Staffed Acute Care Beds in Waterbury Area by Service Line, FYs 2004 - 2006

		Staffed Beds					Share of Staffed Beds	
Service Line	Licensed Beds	FY 2006	FY 2005	FY 2004	% of Licensed Beds Staffed in FY 2006	% of All Staffed Beds in FY 2006	St. Mary's Hospital	Waterbury Hospital
Medical/Surgical	479	260	257	249	54%	58%	40%	60%
OB/GYN	64	62	63	63	97%	14%	50%	50%
Psychiatry	50	42	42	42	84%	9%	29%	71%
Critical Care	75	63	55	55	84%	14%	68%	32%
Pediatric	36	20	20	20	56%	4%	50%	50%
Total Beds	**704**	**447**	**437**	**429**	**63%**	**100%**	**45%**	**55%**
Total Bassinets	**68**	**68**	**68**	**68**	**100%**	**n/a**	**47%**	**53%**

11. Utilization for inpatient hospital services for the two hospitals combined:

Table 4: Waterbury Area Hospitals Acute Care Discharges by Service Line, FYs 2004 - 2006

	Discharges				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Medical	12,546	12,563	12,055	**12,388**	0	4	4
Surgical	7,548	7,527	7,352	**7,476**	0	2	3
Behavioral Health	1,538	1,721	1,650	**1,636**	-11	4	-7
Maternity/Pediatrics	5,930	5,942	6,118	**5,997**	0	-3	-3
Total	**27,562**	**27,753**	**27,175**	**27,497**	**-1**	**2**	**1**

12. The two hospitals combined have 73 emergency "beds" with the following breakdown by hospital:

Table 5: Waterbury Area Hospitals Emergency Department Beds, 2006

St. Mary's Hospital		Waterbury Hospital	
Description	Beds	Description	Beds
Treatment Room	24	Acute ER	21
Trauma room	2	Prompt Care	5
Behavioral Health	5	Behavioral Health	4
Urgi-care room	7	Surge (for high census & boarders)	5
Total	**38**	**Total**	**35**

13. SMH and WH report high utilization rates of emergency department (ED) visits when compared to the state and nation.

14. ED utilization broken down by hospital and combined:

Table 6: Waterbury Area Hospital Emergency Department Utilization, FYs 2004 - 2006

Hospital		FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	Treated & Discharged[1]	56,170	55,165	52,044	54,460
	Treated & Admitted[1]	8,286	8,177	7,581	8,015
	All ED Visits	64,456	63,342	59,625	62,474
Waterbury	Treated & Discharged	43,360	45,506	44,581	44,482
	Treated & Admitted	8,828	8,126	8,075	8,343
	All ED Visits	52,188	53,632	52,656	52,825
Waterbury Area Hospitals	**Treated & Discharged**	**99,530**	**100,671**	**96,625**	**98,942**
	Treated & Admitted	**17,114**	**16,303**	**15,656**	**16,358**
	All ED Visits	**116,644**	**116,974**	**112,281**	**115,300**
ED Utilization Per 1,000		558	560	538	552

15. Utilization of medical outpatient clinics vary by hospital as well as which type of services are offered. The two tables measure such activity; however, it was not determined that this data is comparable.

Table 7: St. Mary's Hospital Medical Clinic Visits by Service Line, FYs 2004 – 2006

	Visits				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Family Health	21,830	25,313	22,927	**23,357**	-14	10	-5
Children's Health	17,732	18,146	17,524	**17,801**	-2	4	1
Dental	7,460	6,715	6,342	**6,839**	11	6	15
Total	**47,022**	**50,174**	**46,793**	**47,996**	-6	7	0

Table 8: Waterbury Hospital Clinic Visits by Service Line, FYs 2004 - 2006

	Visits				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Chase Outpatient Center	10,712	8,581	10,806	**10,033**	25	-21	-1
HIV	1,138	997	451	**862**	14	121	60
Total	**11,850**	**9,578**	**11,257**	**10,895**	24	-15	5

16. Utilization of Outpatient Psychiatric Clinics vary by hospital as well as which type of services are offered. The table below measures such activity; however, it was not determined that this data is comparable.

Table 9: Waterbury Area Hospitals Outpatient Psychiatric Cases, Visits and Average Visits per Case, FYs 2004 - 2006

	Number of Cases				% Change		
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
St. Mary's	1,026	929	816	**924**	10	14	26
Waterbury	10,978	11,428	11,854	**11,420**	-4	-4	-7
Waterbury Area	**12,004**	**12,357**	**12,670**	**12,344**	-3	-2	-5
	Number of Visits				% Change		
Hospital	FY2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
St. Mary's	6,712	5,898	3,731	**5,447**	14	58	80
Waterbury	26,100	28,601	29,566	**28,089**	-9	-3	-12
Waterbury Area	**32,812**	**34,499**	**33,297**	**33,536**	-5	4	-1
	Average Visits/Case						
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average			
St. Mary's	7	6	5	**6**			
Waterbury	2	3	2	**2**			
Waterbury Area	**3**	**3**	**3**	**3**			

17. Utilization of "other" outpatient services (one-day surgery, radiology, laboratory, GI, etc.) is presented below. Data varies between each hospital and may not be consistent or necessarily comparable.

Table 10: Waterbury Area Hospitals Other Outpatient Utilization, FYs 2004 - 2006

	Visits				% Change		
Hospital	FY2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
St. Mary's	135,516	131,538	141,478	136,177	3	-7	-4
Waterbury	110,122	111,971	119,728	113,940	-2	-6	-8
Waterbury Area	**245,638**	**243,509**	**261,206**	**250,118**	1	-7	-6
Utilization Per 1,000	1,176	1,166	1,251	1,198			

18.

Table 11: Waterbury Area Hospitals Primary Payer Payment to Cost, FYs 2003 - 2005

	St. Mary's Hospital			Waterbury Hospital			Connecticut		
	FY03	FY04	FY05	FY03	FY04	FY05	FY03	FY04	FY05
Ratio of cost to charges	0.44	0.44	0.47	0.42	0.36	0.34	0.49	0.46	0.44
Medicare payment to cost	1.03	1.12	1.03	0.89	0.95	0.96	0.97	0.97	0.97
Medicaid payment to cost	0.85	0.80	0.47	0.68	0.82	0.79	0.73	0.73	0.72
Private payment to cost	0.95	1.08	0.96	1.02	1.07	1.06	1.14	1.18	1.20

Source: *Office of Health Care Access Hospital Financial Stability Reports for multiple years*

19.

Table 12: Waterbury Area Hospitals Payer Mix by Department, FYs 2004 - 2006

Services	Primary Payer	St. Mary's (%)			Waterbury (%)			Waterbury Area Hospitals (%)		
		FY06	FY05	FY04	FY06	FY05	FY04	FY06	FY05	
Inpatient Discharges	Medicare	42	43	43	44	43	43	43	43	43
	Medicaid	25	23	23	21	20	20	23	22	21
	Commercial	31	32	32	33	34	34	32	33	33
	Worker's Compensation	1	1	1	1	1	1	1	1	1
	Self-pay/uninsured	1	1	1	1	2	1	1	1	1
		100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Department Treated and Discharged Visits	Medicare	14	15	15	17	18	18	15	16	16
	Medicaid	49	46	43	34	33	32	42	40	38
	Commercial	26	27	29	36	37	37	30	32	33
	Worker's Compensation	2	2	3	3	3	3	2	3	3
	Self-pay/uninsured	9	9	10	11	10	10	10	10	10
		100%	100%	100%	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health Visits	Medicare	9	13	9	46	47	45	43	44	42
	Medicaid	55	58	54	37	35	38	38	37	39
	Commercial	36	28	36	15	16	16	17	17	17
	Worker's Compensation	0	0	0	0	0	0	0	0	0
	Self-pay/uninsured	1	1	0	2	2	2	2	2%	2
		100%	100%	100%	100%	100%	100%	100%	100%	100%
All Other Outpatient Visits	Medicare	32	33	32	30	31	32	31	32	32
	Medicaid	17	17	16	18	18	18	18	18	17
	Commercial	47	47	46	45	45	45	46	46	45
	Worker's Compensation	1	1	3	1	1	1	1	1	2
	Self-pay/uninsured	2	2	3	5	5	4	4	3	4
		100%	100%	100%	100%	100%	100%	100%	100%	100%
Hospital Total	**Medicare**	**28**	**28**	**28**	**32**	**33**	**33**	**30**	**31**	**31**
	Medicaid	**26**	**26**	**24**	**20**	**19**	**19**	**23**	**23**	**22**
	Commercial	**41**	**41**	**41**	**42**	**42**	**42**	**41**	**42**	**41**
	Worker's Compensation	**2**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	**2**
	Self-pay/uninsured	**4**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	**4**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

20.

Table 13: Waterbury Area Hospitals Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 - 2006

Service Line	Gain or Loss Per Discharge/Case ($)				% Change		
	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Medical	(127)	62	322	**82**	-306	-81	353
Surgical	(1,871)	(1,112)	(850)	**(1,282)**	68	31	55
Behavioral Health	(2,834)	(1,805)	(1,472)	**(2,015)**	57	23	48
Maternity/Pediatrics	(794)	(765)	(927)	**(830)**	4	-18	-17
Total	**(899)**	**(549)**	**(386)**	**(612)**	64	42	57

[1] The combined per case gain/loss is sum of total revenue for the two hospitals minus the sum of their total costs divided by sum of discharges from both hospitals.

Table 14: Waterbury Area Hospital Emergency Department Gain or Loss Per Treated & Discharged Visit, FYs 2004 - 2006

Hospital	Gain or Loss Per Discharge/Visit ($)			
	FY 2006	FY 2005	FY 2004	3 Yr. Average
St. Mary's	(22)	(15)	24	(5)
Waterbury[2]	(36)	(29)	(30)	(32)
Waterbury Area Hospitals	**(28)**	**(21)**	**(1)**	**(17)**

[1] For each cell, the combined per case gain/loss is sum of net revenues for the two hospitals minus the sum of total costs for the two divided by sum of discharges from both hospitals.

21. SMH and WH jointly contracted with The Chartis Group, LLC to conduct an assessment and financial review to present options of integration of the two hospitals. The table below summarizes the costs associated with the different Levels:

Table 15: Projected Costs Associated with Levels of Integration.

	Level One ("Millions")	**Level Two** ("Millions")	**Level Three** ("Millions"
A. Affiliation Costs	$ 12.0	$ 17.0	$ 25.0
B. Technical Costs	$ 12.2	$ 12.2	$ 12.2
C. Facilities Costs	$ 1.0	$ 3.9	$ 62.2
	$ 25.2	**$ 33.1**	**$ 99.4**

Level 1: Administrative and Operational Support Integration only
Level 2: Limited Clinical Integration and Level 1
Level 3: Full Administrative and Clinical Integration

22. According to The Chartis Group presentation, all levels of integration show a positive financial gain 5 years out. There would be a significant spend down or depletion of WH cash reserves to facilitate the affiliation. Therefore, WH would be at risk of violating some of its bond covenants and possibly alter its credit profile and its future access to capital.

23. According to The Chartis Group presentation, SMH and WH have internal issues that would need to be addressed, such as: Catholic and Secular organizations, WH has a unionized workforce, SMH liabilities, and a general cultural divide between the two organizations.

24. StayWell Health Center is a federally-qualified health center located in Waterbury, Connecticut, and provides primary care, dental and behavioral health services.

25. In fiscal year 2006, StayWell provided 55,687 visits, a rate of growth of 275% When compared to fiscal year 2000.

26. According to StayWell's letter to the agency, the organization struggles with staffing. "With the shortage in qualified nurses, we are frequently competing for staff. We have seen this to be the case for physicians also. Hiring culturally competent staff is always a struggle and then unfortunately added to the existing community shortages. Ultimately, staffing shortages impact access to care when special outreach services or walk-in hours need to be suspended due to inadequate staff to assign."

27. According to StayWell's letter, "We have difficulty getting access to Specialists who are not interested in seeing our patients. The low reimbursement rates for Title 18 and Title 19 for non-community health care providers has a trickle down effect on our patients."

28. According to a recent telephone conversation held between Commissioner Vogel and Donald Thompson of StayWell, in general StayWell Health Center's growth is limited by the space it occupies.

29. Connecticut has experienced 6 mergers; one closure of a small rural community hospital; one acquisition and conversion of a small non-profit to the state's only for-profit hospital; and the construction of a new children's hospital and a 94-bed community hospital (both results of mergers).

30. After reviewing the closures and mergers, it was apparent that each circumstance was different depending upon the financial strengths and weakness of the hospitals involved. In all of the mergers (in the cities of Bridgeport, Hartford and Meriden) one hospital was financially capable of absorbing the debt of the less viable; and in no circumstances was the State of Connecticut financially responsible for merger/closure activity.

31. The "Report of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Group" examined the previous report regarding the current situation of inpatient services available for children & adolescents and offered recommendations to address the need and capacity for such services.

32. Region 5 has six acute care hospitals (Charlotte Hungerford, New Milford, Sharon, Danbury, St. Mary's and Waterbury) but has only five inpatient beds to serve the area and no free-standing psychiatric hospital.

33. The five inpatient beds for adolescent behavioral health services are located at Waterbury Hospital.

34. The Implementation Group recommends an additional 20 to 30 inpatient psychiatric beds are required in Region 5.

35. The data indicate that the majority of discharges are from the areas of Waterbury (27%), Danbury (11%), and Torrington (8%).

36. The Implementation Group recommends to establish 15 – 25 Psychiatric Residential Treatment Facility beds in Region 5.

IV. Discussion and Conclusion

The main purpose and intent of the processes undertaken by OHCA under the Investigative Proceeding of Docket Number 06-30760-INV was to gather and analyze pertinent data and facts regarding the utilization, capacity and demand, and the challenges to meet these demands in the Waterbury area. The financial condition of both SMH and WH were critical to this assessment. The following is a discussion of the results of the analysis and OHCA's conclusions. All conclusions are independent of Certificate of Need decisions and any review and issuance of CHEFA bonds. Any coordination of services must proceed in full conformance with the antitrust laws.

Throughout this investigation it became evident, either through data or by comments of those involved, that having two hospitals within the city of Waterbury is a root cause for the financial hardship experienced by both hospitals. As a community served by one hospital and one outpatient services system the financial stability of the remaining hospital would return through:

- Improved commercial payer rates
- Improved payer mix of patients
- Reduced expenses related to marketing/advertising/recruitment
- Reduced expenses in duplicative services
- Gain a competitive advantage over hospitals located in the secondary markets

Ideally this one inpatient/outpatient system would further develop an integrated and comprehensive primary care and behavioral health care system with the overriding goal to improve the health status of the community and reduce the number of ED visits and unnecessary hospitalizations.

There has been much discussion regarding the state's Medicaid reimbursement being a lead factor in the financial deterioration since a large portion of the patients are covered by Medicaid. A brief review of the percentage of Medicaid inpatient discharges from other hospitals located in similar markets shows that St. Mary's is the third highest Medicaid inpatient provider and Waterbury Hospital is within the state's average. As Table 1 demonstrates, it is difficult to directly correlate the percentage of inpatients by payer source to profit margins. Payer mix is a strong variable in a hospital's financial condition, but other operational factors play a significant role as well. The patient mix for ED discharges for St. Mary's is 49% and for Waterbury Hospital is 34% (comparable data for other hospitals is not available).

Table 1. FY06 Inpatient Discharge Patient Mix by Payer Source; Total Discharges, Total Profit Margin and Operating Profit Margin

Hospital	Medicare	Medicaid	Private	Uninsured	Total Discharges	Total Margin	Operating Margin
Bridgeport	34%	25%	38%	2%	19,574	4.1%	1.4%
St. Vincent's	46%	14%	35%	5%	19,672	9.4%	3.8%
Hartford	38%	18%	41%	3%	39,323	2.4%	0.0%
St. Francis	41%	20%	37%	2%	31,647	1.0%	-0.1%
Yale-New Haven	28%	25%	44%	2%	50,354	3.9%	2.1%
St. Raphael	53%	13%	33%	1%	25,354	-2.1%	-2.6%
Stamford	35%	16%	46%	4%	17,003	6.1%	5.1%
New Britain	41%	21%	35%	3%	18,585	4.3%	3.3%
St. Mary's	42%	23%	33%	2%	12,718	0.4%	-3.7%
Waterbury	45%	18%	35%	2%	15,000	-2.4%	-3.6%
Statewide	40%	17%	39%	3%	423,051	2.5%	0.6%

Source: OHCA Discharge Database and FY06 Financial Audited Statements (profit margins are hospital only)

Although any improvement to any of the payer reimbursement will benefit the two hospitals – it alone will not address the fundamental issues of fragmentation, duplication, competition and the ability to improve access to capital.

Recently the hospitals have engaged in discussions on the matter of integrating or consolidating services. They jointly contracted a consultant and shared some of the findings as part of this investigation. The consultant's analysis explored the potential options and the costs associated with each option. Realizing that "Level 1 Integration of Administrative and Operational Support Only" would be the most achievable first step, it offers limited long-term sustainability, costs an estimated $25 million, would continue the two-hospital campus with different organizational cultures, and it would have difficulties differentiating itself in the marketplace. The other levels of integration begin to consolidate services and structurally become one hospital with two locations. The costs rise significantly with these options from approximately $33 to $100 million; however, they begin to realize the benefits of a merged entity.

These figures are only estimates; however, they provide insight to the real costs of integration. In other mergers that have occurred in Connecticut (Attachment D), typically one of the hospitals involved was financially capable of absorbing the debt of the less viable hospital and the associated costs of the merger. Of concern is the inability of the hospitals to fund the potential integration.

This situation differs from other mergers in the state because both hospitals are in financial distress and utilization of services remains active. If a merger were to occur, Waterbury Hospital would be responsible to absorb any liabilities and debt of St. Mary's Hospital and that will further weaken the stability of Waterbury Hospital. The hospitals

are aware of some services that can be consolidated (termination of services from one hospital and transferring the patients to the remaining program may require Certificate of Need approval). Such services may include neurology, certain surgical procedures, orthopedics, cardiology, maternity, neonatology, the on-call system for the coverage of two EDs, trauma services, and ancillary services (i.e., laundry, laboratory, pathology, etc.). A slow and deliberate closure of St. Mary's Hospital may also be a viable option.

In conclusion, St, Mary's Hospital's financial measures indicate that the hospital is insolvent. The annual infusion of state funding, although enabling continued access for patients, does not address nor resolve the fundamental system issues that are creating the on-going losses. St. Mary's Hospital should be responsible for providing adequately for its employees during this transition and fully fund the pension obligation. In the event of a closure or merger, the remaining hospital will be able to absorb some of the volume; however, it will need to reconfigure and possibly expand the inpatient services. Removing the competition and duplication in the profitable outpatient market is critical to be able to flow funds back into the remaining hospital system to ensure sustainability.

The infrastructure for primary care and behavioral health care services needs to be re-designed and a comprehensive and integrated system developed. Ideally, a system of care that involves the hospital, the community health centers, community providers and school-based clinics will serve the population well. Additionally, the community may benefit from a workforce development plan as the system begins to reshape the health care delivery system.

St. Mary's Hospital, the Waterbury Hospital and the state agencies were actively involved in this investigatory process. Both hospitals are committed to providing high quality patient care and continue discussions regarding how to best sustain access and return financial stability to the delivery system of the Waterbury community.

Attachment A

State of Connecticut

REPORT OF SOCIO-ECONOMICS AND HEALTH CARE SERVICES UTILIZATION OF THE WATERBURY AREA

Docket Number 06-30760-VST

Cristine A. Vogel
Commissioner
Office of Health Care Access

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1.0 Introduction

On May 25, 2006, the Office of Health Care Access (OHCA) pursuant to Connecticut General Statutes (C.G.S.) Section 19a-633 (Appendix A), initiated an investigation to review utilization and capacity of acute care general hospital services provided in the "Waterbury Area." The general acute care hospitals located in the city of Waterbury are St. Mary's Hospital and The Waterbury Hospital.

The investigation stemmed from concerns about the long-term viability of either or both hospitals, and their ability to provide and maintain needed health care services in the communities they serve vis-à-vis their financial performance in the last two fiscal years (FY) (Table 1). In addition to providing acute inpatient care, the hospitals serve as a safety net for residents of the area who do not have access to or cannot afford primary care. Based on the hospitals audited financial statements, both hospitals are operating at a loss from direct patient care; the hospitals' expenses exceed revenue from direct patient care and other operating revenue; inadequate funds obtained from philanthropic or non-philanthropic sources not directly related to patient care; as well as other issues discussed in this report.

Table 1: Financial Performance of St. Mary's and Waterbury Hospitals (FYs 2004 – 2006)

Financial Indicators	St. Mary's Hospital			Waterbury Hospital		
	FY 2004	FY 2005	FY 2006	FY 2004	FY 2005	FY 2006
Operating Loss/Gain[1]	$6,306,000	$(15,270,000)	$(9,694,000)	$(448,506)	$(2,431,845)	$(5,262,405)
Excess of Revenue over Expenses[2]	$11,480,000	$(6,581,000)	$(6,197,000)	$2,275,334	$(30,448)	$(2,479,026)
Operating Margin[3]	4.2%	(10.02)%	(4.7)%	(0.2)%	(1.2)%	(2.2)%
Total Margin[4]	7.68%	(4.3)%	(3.0)%	1.2%	(0.01)%	(1.1)%

Source: *Audited Financial Statements.*
[1] Loss or gain from reimbursement of patient services from government and non-government payers.
[2] Difference between revenue obtained from direct patient care and funds from other sources and expenses.
[3] Measures profitability and is the ratio of loss or gain per unit total operating revenue.
[4] Measures profitability and is the ratio of total operating and non-operating revenue loss or surplus to total operating revenue.

The investigation reviews current availability and utilization of, and demand for hospital services, system capacity and the challenges these two hospitals face in meeting demands from the community they serve. This involves an evaluation of:

- the socio-economic make-up of the community that relies on services of the hospitals, implications on the hospitals' patient payer-mix and the effect of reimbursements on hospital operations and future plans;
- current utilization and future demand for all hospital services including inpatient, emergency department, primary care clinics, outpatient psychiatric care and ancillary outpatient services in the area; and
- challenges that exist in the market in general and their impact on the hospitals' operations.

On the basis of this investigative proceeding, OHCA will make recommendations for ensuring continued availability and access to health care for the area.

2.0 Determining the towns of the "Waterbury Area"

The towns a hospital provides services to make up its primary and secondary service areas. Primary service area towns are either a significant portion of the hospital's patient base or most residents from the towns access services at the hospital; and the secondary service area consists of all other towns whose residents access the hospital's services at a steady but lower rate. This investigation determines which towns will be most adversely impacted if one of the two hospitals or both are unable to provide services. Therefore, to determine which towns rely significantly on health care services that the two hospitals provide, OHCA first included towns that comprise the top 70% of each of the two hospitals' acute care inpatient discharges. Based on this definition, OHCA identified Waterbury and Naugatuck for St. Mary's Hospital and these same towns and an additional two, Watertown and Southbury, for the Waterbury Hospital (Table 2).

Table 2: Towns of Origin for St. Mary's Hospital and Waterbury Hospital Top Seventy Percent Discharges (FY 2003 – 2005)

	St. Mary's Hospital			Waterbury Hospital		
Patient Town	# Discharges	% of Hospital Total	Cum % Total	# Discharges	% of Hospital Total	Cum % Total
Waterbury	21,903	60.2	60.2	20,818	46.1	46.1
Naugatuck	3,693	10.2	70.4	4,685	10.4	56.5
Watertown	n/a	n/a	n/a	4,610	10.2	66.7
Southbury	n/a	n/a	n/a	2,588	5.7	72.4

Source: *Office of Health Care Access Acute Care Discharge Database*

Other towns were included if the combined share of patients originating from that town for the two hospitals exceeded 70%, demonstrating a significant reliance of the town on the health care system in Waterbury. Middlebury, Prospect and Wolcott became part of the group because the two hospitals account for about three-quarters of discharges originating from each town, bringing the number of towns in the "Waterbury Area" to seven, namely Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown and Wolcott (Table 3).

Table 3: Percent of Patients from Selected Towns Discharged from St. Mary's Hospital and Waterbury Hospital (FY 2003-2005)

Patient Town	St. Mary's Hospital % Share	Waterbury Hospital % Share	Combined % Share
Middlebury	21.5%	53.5%	75.0%
Naugatuck	32.5%	41.2%	73.7%
Prospect	35.7%	37.4%	73.1%
Southbury	7.7%	34.9%	42.6%
Waterbury	44.6%	42.4%	87.0%
Watertown	20.3%	62.7%	83.0%
Wolcott	41.2%	30.7%	71.9%

Source: *Office of Health Care Access Acute Care Discharge Database*

Patients residing in the seven towns included make up over 80% of each hospital's discharges. Although residents of those towns migrate to nearby hospitals to receive care most utilize the Waterbury hospitals more than any other single hospital (Table 4). Patient migration to access care in other areas depends on factors such as patient preference, patient ability to travel and physician referral patterns. Out-migration from local areas also occurs because certain treatment modalities or physician specialists are available outside the Waterbury area.

Table 4: Other Connecticut hospitals' percentage share of discharges originating from the seven selected towns, FYs 2003-2005

Acute Care Hospital	Middlebury %	Naugatuck %	Prospect %	Southbury %	Waterbury %	Watertown %	Wolcott %	% of Hospital Total
St. Mary's	**21.5**	**32.5**	**35.7**	**7.7**	**44.6**	**20.3**	**41.2**	**81.2**
Waterbury	**53.5**	**41.2**	**37.4**	**34.9**	**42.4**	**62.7**	**30.7**	**86.5**
Bridgeport	2.0	3.1	2.6	2.1	1.4	2.1	1.6	2.6
Danbury	5.7	2.1	0.5	38.9	1.1	1.9	0.5	6.8
John Dempsey	0.8	0.8	1.1	0.7	0.8	0.7	1.9	2.7
Griffin	1.1	5.9	1.4	1.7	0.5	0.4	0.3	5.2
St. Raphael's	2.8	2.5	4.8	1.8	1.5	1.4	2.6	2.1
Yale	6.8	5.9	8.7	6.2	3.6	4.7	4.2	2.8
Other*	5.7	6.0	7.8	6.0	4.3	5.8	17.1	0.6
Total (%)	**100**	**100**	**100**	**94**	**100**	**100**	**100**	
# of Discharges	**2,062**	**11,365**	**3,144**	**7,413**	**49,156**	**7,349**	**5,395**	

Source: *Office of Health Care Access Acute Care Discharge Database*
*Includes the other 23 hospitals, which individually did not discharge a significant share of patients from the seven towns.

3.0 Socio-economic profile of the Waterbury Area

Socio-economic status, that is age, gender, race or ethnicity, educational attainment, employment status and income and physician availability, are well-documented joint indicators of health status, need for health care services, timeliness of heath care treatment, and ability to pay for health care services. Therefore, this section examines the social and economic characteristics of the Waterbury area population for insight into the type of services needed, the ability to pay for and the ease of access to health care services. The section also provides information on the inherent patient payer mix experienced by both hospitals.

A. Population and age distribution

According to Census 2000, there are approximately 208,861 residents in the Waterbury area, which is 6% of the state's population. About 51.4% of the area's residents live in Waterbury, 14.8% in Naugatuck and 10.4% in Watertown and a combined 23.4% in Southbury, Wolcott, Prospect and Middlebury (Table 5).

Table 5: Population and Age Distribution of the Waterbury Area

Patient Town	0-19	20-44	45-64	65-74	75+	2000 Population	% of Total
Middlebury	26.0%	28.0%	29.3%	8.0%	8.4%	6,451	3.1%
Naugatuck	29.1%	38.1%	21.0%	5.4%	6.3%	30,989	14.8%
Prospect	26.9%	33.7%	26.0%	6.8%	6.3%	8,707	4.2%
Southbury	24.0%	24.8%	25.1%	9.9%	16.2%	18,567	8.9%
Waterbury	28.9%	36.3%	19.7%	6.7%	8.2%	107,271	51.4%
Watertown	26.7%	34.2%	24.8%	7.0%	7.0%	21,661	10.4%
Wolcott	27.9%	34.9%	23.9%	6.9%	6.1%	15,215	7.3%
Total	**28.1%**	**34.9%**	**21.8%**	**6.9%**	**8.3%**	**208,861**	**100.0%**
Connecticut	**27.1%**	**35.8%**	**23.1%**	**6.7%**	**7.0%**	**3,405,565**	

Source: *U.S. Census Bureau Census 2000*

Some age characteristics of this area are:

- Children under 19 years old are overrepresented in Naugatuck although there is no significant difference between children's share of the area and state population.
- Naugatuck and Waterbury residents, representing almost two-thirds of the area, have a relatively larger share of 20 to 44-year olds. According to OHCA research, 19 to 29 year-olds are four times as likely to be uninsured because they may be full-time students, single, unemployed or have no permanent full-time jobs. This means they are less likely to have health insurance coverage through an employer, are too old to receive coverage from a parent who has coverage through an employer and are incligible for Medicaid.[1]
- Fewer adults in the 45 to 64 age range, a group that is likely to be employed and insured, compared to the state.[2] In Waterbury, there are only 19.7% in this age range compared to 23.1% in the state.
- Waterbury, representing about one-half of the area, has relatively more residents over 75 years than the state, 8.2% versus 7.0%. This age group has the highest potential to suffer from chronic diseases, experiences greater disease acuity and tend to have higher hospitalization rates than the general population and therefore costs more to treat.[3] Older residents are also less mobile and tend to access care in the local area.

B. Gender mix

The gender mix provides information on the types and volume of services the area needs. The gender mix of the area is similar to that of the state with slightly more women than men, although Southbury, Waterbury, Watertown have relatively more women than average (Table 6). Generally younger women tend to require hospitalization 2.5 times as more frequently as their male counterparts due to pregnancies and childbirth, but this disparity narrows, as women get older. In fact, even at age 65 and over when hospitalizations are 2.6 times the rate for the general population, men tend to require acute care at a higher rate than women of the same age cohort.[4]

Table 6: Gender Mix of Waterbury Area

Patient Town	Males	Females	Males %	Females %
Middlebury	3,127	3,324	48.5	51.5
Naugatuck	15,069	15,920	48.6	51.4
Prospect	4,255	4,452	48.9	51.1
Southbury	8,633	9,934	46.5	53.5
Waterbury	50,781	56,490	47.3	52.7
Watertown	10,379	11,282	47.9	52.1
Wolcott	7,411	7,804	48.7	51.3
Total	**99,655**	**109,206**	**47.7**	**52.3**
Connecticut	**1,649,319**	**1,756,246**	**48.4**	**51.6**

Source: *U.S. Census Bureau Census 2000*

C. Racial composition

Research shows that minorities[5], especially Blacks and Hispanics or Latinos, are hospitalized at rates disproportionate to their share of the population than Whites.[6] Hispanics or Latinos are also 3.5 times as likely to be uninsured as all races in the state.[7] Six of the towns in the area are predominantly White compared to the state in general, but because Waterbury, which is about one-half of the area, has a significantly large minority population, mostly Hispanics and Blacks, the area has almost 1.5 times more minorities than the state (Table 7).

Table 7: Racial and Ethnic Distribution of Residents in the Waterbury Area

			Minorities			
Patient Town	Total Population	% White Alone	% Hispanic/Latino (of any race)	% Black Alone	% Asian Alone	% Other races excluding Hispanics/Latinos
Middlebury	6,451	96.2	1.2	0.4	1.3	0.9
Naugatuck	30,989	88.9	4.5	2.8	1.7	2.1
Prospect	8,707	95.0	1.9	1.4	0.7	1
Southbury	18,567	96.1	1.6	0.5	1.2	0.7
Waterbury	107,271	58.2	21.8	16.3	1.5	2.3
Watertown	21,661	95.2	1.9	0.7	1.3	0.8
Wolcott	15,215	95.2	1.8	1.2	0.7	1
Total	**208,861**	**75.4**	**12.4**	**9.1**	**1.4**	**1.8**
Connecticut	**3,405,565**	**77.5**	**9.4**	**9.1**	**2.4**	**1.6**

Source: *U.S. Census Bureau Census 2000*

D. Educational attainment

In general, higher educational attainment enhances employment prospects and the chances of gaining employment with an employer who provides health insurance coverage for eligible employees, especially for skilled labor. In the Waterbury area, fewer residents 25 years and over graduated from high school or have a college degree than the state in general, 78.9% compared to 84.0%. The residents are also 1.5 times less likely to have a bachelor's degree or higher (Table 8).

Table 8: Educational Attainment of the Waterbury Area 25 Years and Over Population

Patient Town	Population 25 Years and Over	% High School Graduate or Higher	% with Bachelor's Degree or Higher
Middlebury	4,662	91.9	41.5
Naugatuck	20,451	83.0	19.0
Prospect	6,015	87.1	22.8
Southbury	13,727	89.2	31.4
Waterbury	69,791	71.7	13.9
Watertown	14,922	83.8	25.0
Wolcott	10,350	87.8	19.3
Total	139,918	78.9	20.3
Connecticut	2,295,617	84.0	31.4

Source: *U.S. Census Bureau Census 2000*

E. Employment status and occupation

There are also fewer residents of the Waterbury area in the civilian labor force relative to the state, 49.3% versus 51.6%. The area total is lower mainly because only 46.4% of the city of Waterbury's residents are in the labor force (Table 9). Regardless, the city also has the highest unemployment rate, over 1.5 times the rate for the state, 8.6% versus 5.3%. This means potentially more people in the area are unable to afford needed health care services.

Table 9: Employment Status of Waterbury Area 16 Years and Over Civilian Labor Force

		Population 16 Years and Over		
Patient Town	Population	% in Civilian Labor Force	% of Civilian Labor Force Employed	% of Civilian Labor Force Unemployed
Middlebury	6,451	52.9	97.5	2.5
Naugatuck	30,989	53.1	94.7	5.3
Prospect	8,707	55.1	97.9	2.1
Southbury	18,567	44.6	96.9	3.1
Waterbury	107,271	46.4	91.4	8.6
Watertown	21,661	54.9	95.4	4.6
Wolcott	15,215	54.6	95.7	4.3
Total	**208,861**	**49.3**	**93.7**	**6.3**
Connecticut	**3,405,565**	**51.6**	**94.7**	**5.6**

Source: *U.S. Census Bureau Census 2000*

Only 56.1% residents of the area are in "management and professional' and "sales and office" occupations compared to 65.6% of the state as a whole (Table 10). These occupations tend to be higher paying and permanent full-time positions, which increase the likelihood of being able to afford and/or qualify for employer-sponsored health insurance (ESI) coverage. Instead, area residents, especially those residing in Waterbury, have a comparatively higher tendency to be in "service" and "production, transportation and material moving," occupations that are seasonal, temporary or part-time in nature which lessen residents' ability to qualify for or to afford ESI when offered.

Table 10: Occupations of Waterbury Area 16 Years and Over Civilian Labor Force

Patient Town	% in Management, Professional, & Related Occupations	% in Service	% in Sales & Office	% in Farming, Fishing, Forestry	% in Construction, Extraction, & Maintenance	% in Production, Transportation, Material Moving
Middlebury	52.1	13.3	20.6	0.0	6.0	8.0
Naugatuck	30.3	15.6	25.1	0.1	10.1	19.0
Prospect	37.1	11.3	28.0	0.1	8.6	14.7
Southbury	47.6	11.6	24.2	0.3	8.3	8.0
Waterbury	25.1	20.1	24.6	0.1	8.8	21.4
Watertown	35.5	16.4	23.6	0.1	8.5	15.9
Wolcott	33.9	14.6	28.3	0.1	9.6	13.5
Total	**31.2**	**17.1**	**24.9**	**0.1**	**8.9**	**17.8**
Connecticut	**39.1**	**14.3**	**26.5**	**0.2**	**8.0**	**12.0**

Source: *U.S. Census Bureau Census 2000*

F. Per capita and average household incomes

Higher individual or family incomes are linked to greater ability and willingness to spend on needed health care services. Per capita and average household incomes are the proxies for measuring what an individual or a family can afford. For most towns in the Waterbury area, both amounts are below the state average, resulting in a low average for the area in general, $28,505 versus the state's $31,816 and $76,939 compared to $82,601 (Table 11).

Table 11: Per Capita and Average Household Income for Waterbury Area Residents

Patient Town	Per Capita Income ($)	Median Household Income ($)	Average Household Income ($)
Middlebury	39,129	68,090	105,684
Naugatuck	25,477	56,677	67,314
Prospect	26,881	68,770	79,946
Southbury	34,318	64,437	85,269
Waterbury	21,238	41,258	51,888
Watertown	24,276	57,832	66,766
Wolcott	28,214	71,144	81,709
Total	**28,505**	**64,437**	**76,939**
Connecticut	**31,816**	**59,697**	**82,601**

Source: *CT Department of Economic & Community Development 2000 Data from Claritas*

G. Estimated rate and number of uninsured

The "estimated" uninsured rate for Waterbury area residents based on the OHCA 2006 Household Survey is over 1.5 times the rate for the state, that is, 9.8% compared to 6.4% (Table 12).

Table 12: Estimated rate and number of uninsured in Waterbury Area, 2006

Uninsured Rate (%)			Estimated Number of Uninsured		
Lower	Estimate	Upper	Lower	Estimate	Upper
5.9	**9.8**	13.7	12,688	**21,034**	28,380

Source: CT Office of Health Care Access 2006 Household Survey and U.S. Census Bureau 2005 Population Estimates

[1] The estimated uninsured rate will fall within the given lower and upper boundaries 95% of the time if the survey were repeated 100 times. The estimated rate of uninsured for the state is 6.4%.

H. Rate of preventable hospitalization

Preventable hospitalizations (PH) are acute care admissions that would not have occurred, if patients had received "timely and effective primary care and medical management."[8] Such conditions include asthma, angina, bacterial pneumonia, chronic obstructive pulmonary disease, congestive heart failure, dehydration, diabetes, hypertension, low birth weight, lower extremity amputation, pediatric gastroenteritis, perforated appendix and urinary infection. Based on a methodology developed by the federal Agency for Healthcare Research and Quality (AHRQ), the Waterbury area has a relatively higher incidence of PH than the state for children and adults, 1.9 versus 1.2 and 1.5 versus 1.2 per 1,000 of the respective population (Table 13). For both age groups, the city of Waterbury had the highest incidence of PH, which was also twice the state rate.

Table 13: Ambulatory Care Sensitive Condition* Discharges per 1,000 population, FYs 2000 – 2004

Patient Town	Children (0-17)	Adults (18+)
Middlebury	2	1.3
Naugatuck	1.9	1.8
Prospect	1.7	1.5
Southbury	0.7	1.3
Waterbury	4.2	2.5
Watertown	2.3	1.4
Wolcott	1.8	1.5
Median for Area	**1.9**	**1.5**
Median for Connecticut	**1.2**	**1.2**

Source: *Office of Health Care Access Acute Care Discharge Database*

*Conditions include asthma, angina, bacterial pneumonia, chronic obstructive pulmonary disease, congestive heart failure, dehydration, diabetes, hypertension, low birth weight, lower extremity amputation, pediatric gastroenteritis, perforated appendix and urinary infection.

I. Primary care physicians per 1,000 of area population

There is a recognized link between receiving primary care and improved health status. Payers of health care services broadly define primary care physicians (PCP) to include family or general practice physicians, pediatricians, internists, nurse practitioners, physician assistants and naturopathic physicians. These PCPs, including being trained to treat a wide range of diseases, maintain comprehensive records of patients, refer patients to specialists, coordinate care provided to patients by specialists and facilities, and manage patients' chronic health conditions. Ideally, a PCP should be a patient's first contact in a health care system. But generally, these PCPs are not distributed evenly between communities in the state and across the nation. In November 2005, the Primary Care Office of Connecticut Department of Public Health (DPH) designated the city of Waterbury as a medically and a primary care underserved area under federal law as an initial step to improving access to primary health care in the area.[9]

4.0 Hospital services utilization, payer reimbursement and mix

This section discusses the utilization of hospital services in the Waterbury area and identifies the payers of those services. This includes a discussion of acute care inpatient bed capacity, availability and utilization; emergency department use; outpatient psychiatric and other outpatient services utilization; and payer mix in these areas of operation. Unless otherwise stated, the two hospitals provided all the data for this section in response to OHCA's preliminary questions for the investigation; FY 2006 data are annualized.

A. Inpatient bed capacity, occupancy and availability

The "size" or "capacity" of inpatient services is the average number of inpatient beds a hospital staffs. Occupancy is the average number of staffed beds in use by midnight census throughout the year. The Department of Public Health (DPH) has licensed the two hospitals in the Waterbury area to operate a maximum of 704 beds and 68 bassinets. But over the last three years, the hospitals have gradually increased staffed beds to make available 63% or 447 beds in FY 2006 (Table 15). As a rule of thumb, hospitals obtain bed licenses to their maximum allowable capacity and staff beds based on demand and ability to staff them adequately.

Including critical care beds, about 70% of staffed beds in the area are medical or surgical. According to the two hospitals, in the last year, both have experienced increases in volumes associated with those beds, raising their medical/surgical occupancy rates to over 86% and ICU beds to over 80% for most of the year. Over a three-year period ending in FY 2006, both hospitals gradually added to the number of beds staffed for those services to bring the total to 323 (Table 15, see Appendices 1 and 2 for hospital details). But they staffed psychiatric beds at the same level in three consecutive years although they report occupancy at over 80%.

Table 15: Licensed and Staffed Acute Care Beds in Waterbury Area by Service Line, FYs 2004 - 2006

		Staffed Beds					Share of Staffed Beds	
Service Line	Licensed Beds	FY 2006	FY 2005	FY 2004	% of Licensed Beds Staffed in FY 2006	% of all Staffed Beds in FY 2006	St. Mary's Hospital	Waterbury Hospital
Medical/Surgical	479	260	257	249	54%	58%	40%	60%
OB/GYN	64	62	63	63	97%	14%	50%	50%
Psychiatry	50	42	42	42	84%	9%	29%	71%
Critical Care	75	63	55	55	84%	14%	68%	32%
Pediatric	36	20	20	20	56%	4%	50%	50%
Total Beds	**704**	**447**	**437**	**429**	**63%**	**100%**	**45%**	**55%**
Total Bassinets	**68**	**68**	**68**	**68**	**100%**	**n/a**	**47%**	**53%**

The high demands for medical/surgical, critical care and psychiatric beds are from:

- Growing demand for monitored beds at both hospitals due to an aging population with more complex medical conditions that require higher intensity nursing care;
- Systemic issues caused by difficulty in discharging patients to either extended care facilities or other next level of care resources. Delayed discharge of patients to step down

care because of insufficient availability of the next level of care in the community for both elderly and behavioral health patients; and

- Waterbury Hospital is the only provider of hospital inpatient behavioral health care to adolescents in mental health Region 5[10].

Both hospitals' ability to increase staffed beds to accommodate rising demand for medical, surgical and critical care beds is limited by factors either unique to the individual hospital or widespread in the hospital industry. Some limitations, which continue to exist, include:

- A decommissioned 27-bed unit at St. Mary's Hospital;
- Conversion of semi-private rooms to single occupancy rooms stemming from need to provide privacy and isolation for patients that require it at both hospitals.
- Physical plant constraints including aging building and inefficient configuration of nursing units;
- Restricted access to capital for renovating decommissioned units or converting administrative space to clinical space;
- Difficulty in recruiting additional and retaining existing staff; and
- Regulatory challenges.

In FY 2006, both St. Mary's Hospital and Waterbury Hospital held staffing levels for OB/GYN and pediatric beds consistent with prior years even though both hospitals continue to report low occupancy for the beds.

Based on the area towns identified, which constitutes over 80% of the hospitals' discharges, the area seems to have relatively more staffed medical and surgical acute care beds available per 100,000 of the population than the state as a whole, that is 209 versus 186 per 100, 000 (Table 16). Although psychiatric beds seem sufficient for the area, Waterbury is the sole provider of behavioral health care for residents less than 18 years old in Region 5 and the hospital has assigned five beds to the age group, already deemed inadequate for the region.[11]

Table 16: Licensed and Staffed Acute Care Bed Availability in the Waterbury Area by Service Line, FYs 2004 - 2006

			Waterbury Area			
Service Line	Licensed Beds	FY 2006 Staffed Beds	Census 2000 Population	Licensed Bed Availability per 100,000	Staffed Bed Availability per 100,000	CT Staffed Bed Availability per 100,000
Medical/Surgical[1]	554	323	154,773	358	209	186
OB/GYN[2]	64	62	82,519	78	75	80
Psychiatry[3]	50	42	194,438	26	22	21
Pediatric[4]	36	20	51,520	70	39	33
Total Beds	**704**	**447**	**206,293**	**341**	**217**	**209**
Total Bassinets[5]	**68**	**68**	**2,568**	**2,648**	**2,648**	-

Source: *US Census 2000 & * Studying Health Care Utilization in Connecticut, A Report to the Governor and General Assembly.*

[1] Adults over 17 years old. Beds include critical care beds

[2] Females over 17 years old.

[3] Ages 5 and over.

[4] Population under 18 years old (54,088) minus discharges reported for (5) below.

[5] Bassinets for both nursery and NICU. Population is three-year average number of discharges reported by the two hospitals for discharges assigned Diagnosis Related Group (DRGs) 385-391in the OHCA Acute Care Discharge Database.

B. Acute care inpatient utilization by service type

This section provides an overview of the inpatient (IP) services that Waterbury area residents utilized over the three-year period ending in FY 2006. It combines utilization at both hospitals to better assess the needs of the community overall.

Inpatient medical care is almost one-half of the services the two hospitals provide; surgical and maternity/pediatrics care each account for about one-quarter; and behavioral health is 5%. The two hospitals started a joint advance cardiac services program over a year ago, which generated an increase in volume that was offset by a decline in behavioral health care. The combined inpatient services provided grew by 2% although maternity/pediatric care accessed declined by 3% in FY 2005 (Table 17, see Appendices 3 and 4 for hospital details). The overall increase in discharges in the area was no different from state level increases. Annualized volumes for FY 2006 indicate a significant drop in behavioral health discharges (11%) while discharges for other services will be close to their FY 2005 levels altogether resulting in a 1% decline in inpatient care utilization for the area.

Table 17: Waterbury Area Hospitals Acute Care Discharges by Service Line, FYs 2004 - 2006

	Discharges				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	12,546	12,563	12,055	**12,388**	0	4	4
Surgical	7,548	7,527	7,352	**7,476**	0	2	3
Behavioral Health	1,538	1,721	1,650	**1,636**	-11	4	-7
Maternity/Pediatrics	5,930	5,942	6,118	**5,997**	0	-3	-3
Total	**27,562**	**27,753**	**27,175**	**27,497**	**-1**	**2**	**1**

By the end of FY 2006, although total medical and surgical discharges are expected to remain the same and behavioral health and maternity/pediatric days to reduce, the hospitals anticipate 3% and 10% increases in medical and surgical patient days respectively. The result is a net increase in patient days of 4% for the year and 5% over the three-year period (Table 18, see Appendices 5 and 6 for hospital details).

Table 18: Waterbury Area Hospitals Acute Care Days by Service Line, FYs 2004 - 2006

	Acute Care Days				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	63,472	61,732	58,829	**61,344**	3	5	7
Surgical	39,926	36,345	37,832	**38,034**	10	-4	5
Behavioral Health	11,206	11,893	11,364	**11,488**	-6	5	-1
Maternity/Pediatrics	15,802	15,969	15,980	**15,917**	-1	0	-1
Total	**130,406**	**125,939**	**124,005**	**126,783**	**4**	**2**	**5**

Costs per discharge for all services are rising at both hospitals. Inpatient medical care cost per discharge was higher at Waterbury Hospital while inpatient surgical care cost per discharge was higher at St. Mary's Hospital. But by the end of FY 2006, the costs for both services at the hospitals were almost similar, $8,302 and $15,269 at St. Mary's Hospital versus $8,323 and $15,236 at Waterbury Hospital (Table 19). The converging unit cost for those service lines is better illustrated by the patient resource usage indicator or case mix index which was higher in FY 2003 for Waterbury Hospital but reduced for the hospital for two consecutive years to become almost equivalent to St. Mary's Hospital in FY 2005, 1.3534 versus 1.3577 respectively (for hospital details see Appendix 7). On the other hand, cost per discharge for behavioral health and maternity/pediatric inpatient care continue to be lower at St. Mary's Hospital. Generally, some of the variations in cost are attributable to what is included in cost, which tend to vary from hospital to hospital.

Table 19: Waterbury Area Hospitals Acute Care Cost[1] Per Discharge by Service Line, FYs 2004 - 2006

	St. Mary's Hospital ($)				Waterbury Hospital ($)			
Service Line	FY 2006	FY 2005	FY 2004	3-yr Average	FY 2006	FY 2005	FY 2004	3-yr Average
Medical	8,302	7,043	6,189	**7,211**	8,323	7,779	6,926	**7,676**
Surgical	15,269	12,874	12,391	**13,507**	15,236	12,843	11,776	**13,311**
Behavioral Health	7,303	6,612	5,999	**6,648**	9,376	8,059	7,620	**8,301**
Maternity/Pediatrics	3,095	3,980	3,662	**3,553**	4,260	3,548	3,581	**3,773**
Total	**8,817**	**7,998**	**7,305**	**8,058**	**9,590**	**8,227**	**7,527**	**8,433**

[1] There may be a variation in the components of cost between hospitals.

Medical care, which showed a gain of $62 per case in FY 2005 is projected to convert to a loss of $127 per case in FY 2006; behavioral health care although not the most expensive service to provide, lost the hospitals the most money per discharge, at a loss of $1,805 per case in FY 2005 and is expected to almost double to $2,834 per case in FY 2006 (Table 20, see Appendices 8 and 9 for hospital details). Despite sporadic growth in surgical care, losses per case for the service continue to rise. Based on annualized figures, loss per case for all services will grow by 64% by the end of FY 2006.

Table 20: Waterbury Area Hospitals Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 - 2006

	Gain or Loss Per Discharge/Case ($)				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Medical	(127)	62	322	**82**	-306	-81	353
Surgical	(1,871)	(1,112)	(850)	**(1,282)**	68	31	55
Behavioral Health	(2,834)	(1,805)	(1,472)	**(2,015)**	57	23	48
Maternity/Pediatrics	(794)	(765)	(927)	**(830)**	4	-18	-17
Total	**(899)**	**(549)**	**(386)**	**(612)**	64	42	57

[1] The combined per case gain/loss is sum of total revenue for the two hospitals minus the sum of their total costs divided by sum of discharges from both hospitals.

C. Emergency Department utilization

Emergency Departments (ED) are an essential part of a health care system as they serve as the safety net for communities. For vulnerable populations, they can also be the primary mode of access to health care in general.

Between the two hospitals, the Waterbury area has 73 ED beds (Table 21); St. Mary's Hospital recently added eight of beds in response to continuous growth in volumes. Both hospitals experience "boarding" in the ED where patients wait over 12 hours for admission to an inpatient bed or transferred to mostly psychiatric facilities, throughout the year. Longer wait times and boarding occur mostly for medical/surgical, telemetry and psychiatric patients despite improvements in patient flow processes. The wait for inpatient admits is mostly related to staffing constraints or physical limitations to increase available beds.

Table 21: Waterbury Area Hospitals Emergency Department Beds, 2006

St. Mary's Hospital		Waterbury Hospital	
Description	Beds	Description	Beds
Treatment Room	24	Acute ER	21
Trauma room	2	Prompt Care	5
Behavioral Health	5	Behavioral Health	4
Urgi-care room	7	Surge (for high census & boarders)	5
Total	**38**	**Total**	**35**

Area residents recorded an average of 115,300 ED visits or 552 visits per 1,000 of their population per year (Table 22) which is over 1.3 times the average rate for the state and the nation,[12] an average that continues to rise from year to year. The high utilization rate may be associated with insufficient availability of primary care services in the area; increased demand on EDs to provide primary care after hours coverage; admission of physician referred patients through the ED because of limited capacity to accommodate direct admit patients; and increased patient disease acuity from lack of ongoing preventive care or management.

Table 22: Waterbury Area Hospital Emergency Department Utilization, FYs 2004 - 2006

Hospital		FY 2006	FY 2005	FY 2004	3-yr. Average
St. Mary's	Treated & Discharged[1]	56,170	55,165	52,044	54,460
	Treated & Admitted[1]	8,286	8,177	7,581	8,015
	All ED Visits	64,456	63,342	59,625	62,474
Waterbury	Treated & Discharged	43,360	45,506	44,581	44,482
	Treated & Admitted	8,828	8,126	8,075	8,343
	All ED Visits	52,188	53,632	52,656	52,825
Waterbury Area Hospitals	**Treated & Discharged**	**99,530**	**100,671**	**96,625**	**98,942**
	Treated & Admitted	**17,114**	**16,303**	**15,656**	**16,358**
	All ED Visits	**116,644**	**116,974**	**112,281**	**115,300**
ED Utilization Per 1,000		553	560	538	552

When a patient visits an ED, the patient is either "treated and discharged" or "treated and admitted" to inpatient care or transferred to other types of health care institutions. In the Waterbury area, an average of 16,358 or 14% of ED visits result in an acute care admission, which is similar to 15% in the state. Also similar to the state, inpatients admitted through the ED at the two hospitals have increased from one-third of all acute care inpatients in FY 2004 to one-half in FY 2006. In both instances, admissions through the ED have effectively replaced physician referrals as the primary source of admissions to acute care.

Some of the top ten primary reasons for ED visits for the "treated and discharged" probably could have been taken care of in a doctor's office or a primary care center providing one was available at onset of symptoms (for details see Appendices 10 and 11). The top ten primary reasons Waterbury area hospitals admitted ED patients to inpatient care were mostly cardiac, respiratory or infection related (for details see Appendix 12).

On average, Waterbury Hospital cost per ED per visit is almost 1.5 times St. Mary's cost (Table 23). According to the hospitals, the difference is in the items each hospital includes in its cost structure. For example, in this case St. Mary's Hospital excludes ED-related physician cost but accounts for it in the cost structure of its for-profit affiliate, the Franklin Medical Group, PC. Waterbury Hospital's cost structure also includes the cost of medical liability.

Table 23: Waterbury Area Hospital Emergency Department Cost[1] Per Treated and Discharged Visit, FYs 2004 - 2006

	Average Cost per Visit ($)			
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	290	290	242	274
Waterbury	484	454	444	460
Waterbury Area Hospitals	**374**	**364**	**335**	**358**

[1] There may be a variation in the components of cost between hospitals.

Similar to inpatient care services, both hospitals provide emergency services at a loss per visit; the three-year combined average loss was $17 per "treated and discharged" visit (Table 24). The losses are increasing from year to year. Waterbury Hospital experienced the higher losses per visit than St. Mary's Hospital.

Table 24: Waterbury Area Hospital Emergency Department Gain or Loss Per Treated & Discharged Visit, FYs 2004 - 2006

	Gain or Loss Per Discharged Visit ($)			
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	(22)	(15)	24	(5)
Waterbury[2]	(36)	(29)	(30)	(32)
Waterbury Area Hospitals	**(28)**	**(21)**	**(1)**	**(17)**

[1] For each cell, the combined per case gain/loss is sum of net revenues for the two hospitals minus the sum of total costs for the two divided by sum of discharges from both hospitals.

D. Outpatient services utilization

Outpatient (OP) services the two hospitals provide in the area include medical and dental clinics; behavioral health care and other OP care such as one-day surgery, radiology, laboratory, gastroenterology and other services.

i. Medical clinic utilization

Affiliates of each hospital own and operate the medical outpatient clinics for both hospitals.

Franklin Medical Group, PC (FMG) a for-profit entity, provides adult primary care in its Family Health Center, pediatric primary care in its Children's Health Center and dental care in the Dental Health Center for St. Mary's Hospital. On average, FMG records 47,996 visits per year at the three clinics combined (Table 25). In the last three years, area residents made the largest number of visits in FY 2005 at 50,174, but this dropped by 6% by the end of FY 2006.

Table 25: St. Mary's Hospital Medical Clinic Visits by Service Line, FYs 2004 - 2006

	Visits				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Family Health	21,830	25,313	22,927	**23,357**	-14	10	-5
Children's Health	17,732	18,146	17,524	**17,801**	-2	4	1
Dental	7,460	6,715	6,342	**6,839**	11	6	15
Total	**47,022**	**50,174**	**46,793**	**47,996**	-6	7	0

While visits to the clinics will drop in FY 2006, cost per visit will rise in each clinic to an average $132 for all clinics (Table 26). Except for dental care, cost per visit at each of the other two clinics was lowest at the three-year peak volumes.

Table 26: St. Mary's Hospital Clinics Cost per Visit by Service, FYs 2004 - 2006

	Cost Per Visit ($)				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Family Health	140	117	125	**127**	20	-7	11
Children's Health	138	122	144	**134**	13	-15	-5
Dental	94	79	57	**78**	20	38	39
Total	**132**	**113**	**123**	**123**	16	-8	7

From year to year, FMG operated the three clinics at a loss per visit; by the end of FY 2006, loss per visit will increase by 10% to $77 (Table 27).

Table 27: St. Mary's Hospital Clinics Gain or Loss per Visit by Service, FYs 2004 - 2006

Clinic Service	Gain or Loss Per Encounter ($)				% Change		
	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
Family Health	(93)	(89)	(89)	(90)	4	0	4
Children's Health	(69)	(55)	(79)	(67)	25	-31	-15
Dental	(51)	(40)	(35)	(42)	28	12	30
Total	**(77)**	**(70)**	**(78)**	**(75)**	10	-11	-2

Greater Waterbury Network, Inc owns Chase Outpatient Center and the HIV clinic; but the Greater Waterbury Management Resources, Inc. and Alliance Medical Group, PC operate the two clinics on behalf of Waterbury Hospital. The outpatient center provides primary care, neurology, orthopedics, podiatry and urology services and the other provides HIV-related medical services and counseling to the Waterbury area.

Together the two clinics record an average of 10,895 visits per year and the number of visits is expected to grow by 24% by the end of FY 2006 and 5% in the three-year period (Table 28).

Table 28: Waterbury Hospital Clinic Visits by Service Line, FYs 2004 – 2006

Clinic Service	Visits				% Change		
	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
Chase Outpatient Center	10,712	8,581	10,806	10,033	25	-21	-1
HIV	1,138	997	451	862	14	121	60
Total	**11,850**	**9,578**	**11,257**	**10,895**	24	-15	5

The Waterbury Hospital only provided revenue data for the two clinics because cost at service line level is not available; as a result, OHCA is unable to determine gain or loss per visit at this time.

ii. Behavioral health services utilization

Patients in need of behavioral health care who receive adequate and continuous outpatient care have a reduced tendency to require emergency or inpatient care; therefore, there is a community benefit associated with providing outpatient psychiatric care. The FMG provides adult behavioral and substance abuse care for St. Mary's Hospital, while Behavioral Health of Waterbury Hospital Mental Health Outpatient Services and Behavioral Health of Waterbury Hospital Mental Addiction Services, both owned by Waterbury Hospital, provide psychiatry and addiction treatment for adolescents and children (ten years and older), adults and geriatrics.

Over the three-year period, the psychiatric clinics operated by or on behalf of the two hospitals experienced some decline in number of cases and visits, the facilities treated an average of 12,344 cases in 33,536 visits or 3 visits per case (Table 29). Although Waterbury Hospital clinics treated the overwhelming majority, on average, St. Mary's cases visited the clinics three times as often.

Table 29: Waterbury Area Hospitals Outpatient Psychiatric Cases, Visits and Average Visits per Case, FYs 2004 - 2006

	Number of Cases				% Change		
Hospital	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
St. Mary's	1,026	929	816	924	10	14	26
Waterbury	10,978	11,428	11,854	11,420	-4	-4	-7
Waterbury Area	**12,004**	**12,357**	**12,670**	**12,344**	-3	-2	-5
	Number of Visits				% Change		
Hospital	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
St. Mary's	6,712	5,898	3,731	5,447	14	58	80
Waterbury	26,100	28,601	29,566	28,089	-9	-3	-12
Waterbury Area	**32,812**	**34,499**	**33,297**	**33,536**	-5	4	-1
	Average Visits/Case						
Hospital	FY 2006	FY 2005	FY 2004	3-yr Average			
St. Mary's	7	6	5	6			
Waterbury	2	3	2	2			
Waterbury Area	**3**	**3**	**3**	**3**			

The three-year average costs per visit to psychiatric clinics were similar, $161 for St. Mary's and $162 for Waterbury (Table 30). Prior to FY 2006, the cost of an outpatient psychiatric clinic visit at St. Mary's Hospital was at least 1.5 times higher than one at Waterbury Hospital, but in FY 2006 there was substantial decline in the cost at St. Mary's. Cost per case is higher at St. Mary's Hospital because of relatively more frequent of visits per case (Table 29). Generally, some of the variations in cost are attributable to what is included in cost; components of cost tend to vary from hospital to hospital especially in cases where affiliates provide the service on behalf of the hospital.

Table 30: Waterbury Area Hospitals Outpatient Psychiatric Cost Per Case or Visit, FYs 2004 - 2006

Hospital	Cost Per Case ($)			
	FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	1,625	2,427	2,276	**950**
Waterbury	669	686	638	**398**
Hospital	**Cost Per Visit ($)**			
	FY 2006	**FY 2005**	**FY 2004**	**3-Yr Average**
St. Mary's	248	382	498	**161**
Waterbury	281	274	256	**162**

[1] There may be a variation in the components of cost between hospitals.

Each hospital's affiliate provides outpatient psychiatric services at a loss per case; the average combined losses over the three-year period was $328 with most of the losses occurring at St. Mary's Hospital, because the hospital had higher average number of visits and per unit cost (Table 31). Losses per visit for the hospitals converge in FY 2006 at $115 for St. Mary's and $113 for Waterbury.

Table 31: Waterbury Area Hospital Outpatient Psychiatric Gain or Loss Per Case and Visit, FYs 2004 - 2006

Hospital[1]	Gain or Loss Per Case ($)				% Change		
	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
St. Mary's	(755)	(915)	(1,586)	**(1,053)**	7	-12	-7
Waterbury	(268)	(251)	(287)	**(269)**	3	-19	-16
Waterbury Area	**(310)**	**(301)**	**(370)**	**(328)**	-3	19	-13
Hospital	**Gain or Loss Per Visit ($)**						
	FY 2006	**FY 2005**	**FY 2004**	**3-yr Average**			
St. Mary's	(115)	(144)	(347)	**(179)**	12	-13	-2
Waterbury	(113)	(100)	(115)	**(109)**	5	-23	-20
Waterbury Area	**(113)**	**(108)**	**(141)**	**(121)**	-5	23	-17

[1] Combined per case gain/loss is sum of total net revenue for the two hospitals minus the sum of their total costs divided by sum of cases or visits from both hospitals.

iii. Other outpatient services utilization

Other outpatient services utilization based on data received from the two hospitals consist of services such as one-day surgery, radiology, laboratory, gastroenterology and other services. Ownership structures vary between hospitals and private practice physicians so the data may not be consistent or necessarily comparable.

In the three-year period combined other OP services declined by 6% (Table 32).

Table 32: Waterbury Area Hospitals Other Outpatient Utilization, FYs 2004 – 2006

	Visits				% Change		
Hospital	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
St. Mary's	135,516	131,538	141,478	136,177	3	-7	-4
Waterbury	110,122	111,971	119,728	113,940	-2	-6	-8
Waterbury Area	**245,638**	**243,509**	**261,206**	**250,118**	1	-7	-6
Utilization Per 1,000	1,476	1,466	1,561	1,498			

Other OP services cost per visit at Waterbury was 1.5 times St. Mary's, although this may vary from service to service (Table 33).

Table 33: Waterbury Area Hospital Other Outpatient Cost Per Visit, FYs 2004 - 2006

	Cost Per Visit ($)			
Hospital	FY 2006	FY 2005	FY 2004	3-yr Average
St. Mary's	224	230	214	**223**
Waterbury	363	354	320	**345**
Waterbury Area	**286**	**287**	**263**	**278**

[1] There may be a variation in the components of cost between hospitals.

Despite the declining volumes, both hospitals made some gains per case providing other outpatient services. The two hospitals made experienced gains per visit for three consecutive years with most of the gains occurring at St. Mary's Hospital, (Table 34)

Table 34: Waterbury Area Hospitals Other Outpatient Gain or Loss Per Visit, FYs 2004 - 2006

	Gain or Loss Per Visit ($)			
Hospital	FY 2006	FY 2005	FY 2004	3-yr Average
St. Mary's	25	13	32	**23**
Waterbury[2]	16	15	15	**15**
Waterbury Area Hospitals	**21**	**14**	**24**	**20**

[1] The combined per case gain/loss is sum of total revenue for the two hospitals minus the sum of their total costs divided by sum of discharges from both hospitals.

D. Payer reimbursement and mix

Hospital profitability relies significantly on a balance between patients covered by commercial/private insurance, government sponsored programs, such as Medicare, Medicaid or state or local programs in Connecticut such as State-Administered General Assistance (SAGA), and self-pay or uninsured patients. The driving force behind the gain or loss per case is the source of reimbursement.

Federal and state governments predetermine payment rates for Medicare and Medicaid patients, while hospitals negotiate reimbursement rates with private and commercial payers. In general, Medicaid rates do not fully cover cost while private or commercial programs traditionally reimburse at or above costs, depending on how the negotiated rates favor the hospitals.

In the Waterbury area, Medicare and private payers reimburse slightly above cost but reimbursement rates have been declining from year to year (Table 35). Currently, the two payers reimburse the two hospitals just enough to offset each other's underpayments. In FY 2005, Medicaid reimbursed less than one-half of St. Mary's Hospital's cost and less than 80% of Waterbury Hospital's.

Table 35: Waterbury Area Hospitals Primary Payer Payment to Cost, FYs 2003 - 2005

	St. Mary's Hospital			Waterbury Hospital			Connecticut		
	FY03	FY04	FY05	FY03	FY04	FY05	FY03	FY04	FY05
Ratio of cost to charges	0.44	0.44	0.47	0.42	0.36	0.34	0.49	0.46	0.44
Medicare payment to cost	1.03	1.12	1.03	0.89	0.95	0.96	0.97	0.97	0.97
Medicaid payment to cost	0.85	0.80	0.47	0.68	0.82	0.79	0.73	0.73	0.72
Private payment to cost	0.95	1.08	0.96	1.02	1.07	1.06	1.14	1.18	1.20

Source: *Office of Health Care Access Hospital Financial Stability Reports for multiple years*

i. Hospital payer mix

Commercial payers are the dominant primary payer in the Waterbury Area accounting for 41% of total patient volume all services combined. Medicare accounts for 30%, Medicaid for almost one-quarter and self-pay or the uninsured for 4% (Table 36). In fact, commercial payers are the leading primary payer (46%) in the sole profitable areas of service for the hospitals; other outpatient services, which include one-day surgery, radiology, laboratory, gastroenterology and all other services except ED and outpatient psychiatry. The payer mix varies between services and hospitals. EDs in the area have an unfavorable payer-mix with over one-half of their patient volume being either Medicaid-covered or self-pay or uninsured and an annually declining share of commercially-covered patients. Although both hospitals provide care to a large portion of uninsured patients, 9% for St. Mary's Hospital and 11% for Waterbury Hospital, St. Mary's Hospital treats a disproportionate share (49%) of Medicaid patients in the ED. The payer mix presented in Table 36 is directly and highly correlated to the demographic profile outlined in Section 3.0.

Table 36: Waterbury Area Hospitals Payer Mix by Department, FYs 2004 - 2006

Services	Primary Payer	St. Mary's (%)			Waterbury (%)			Waterbury Area Hospitals (%)		
		FY06	FY05	FY04	FY06	FY05	FY04	FY06	FY05	FY04
Inpatient Discharges	Medicare	42	43	43	44	43	43	43	43	43
	Medicaid	25	23	23	21	20	20	23	22	21
	Commercial	31	32	32	33	34	34	32	33	33
	Worker's Compensation	1	1	1	1	1	1	1	1	1
	Self-pay/uninsured	1	1	1	1	2	1	1	1	1
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Emergency Department Treated and Discharged Visits	Medicare	14	15	15	17	18	18	15	16	16
	Medicaid	49	46	43	34	33	32	42	40	38
	Commercial	26	27	29	36	37	37	30	32	33
	Worker's Compensation	2	2	3	3	3	3	2	3	3
	Self-pay/uninsured	9	9	10	11	10	10	10	10	10
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Outpatient Behavioral Health Visits	Medicare	9	13	9	46	47	45	43	44	42
	Medicaid	55	58	54	37	35	38	38	37	39
	Commercial	36	28	36	15	16	16	17	17	17
	Worker's Compensation	0	0	0	0	0	0	0	0	0
	Self-pay/uninsured	1	1	0	2	2	2	2	2%	2
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
All Other Outpatient Visits	Medicare	32	33	32	30	31	32	31	32	32
	Medicaid	17	17	16	18	18	18	18	18	17
	Commercial	47	47	46	45	45	45	46	46	45
	Worker's Compensation	1	1	3	1	1	1	1	1	2
	Self-pay/uninsured	2	2	3	5	5	4	4	3	4
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Total	**Medicare**	**28**	**28**	**28**	**32**	**33**	**33**	**30**	**31**	31
	Medicaid	**26**	**26**	**24**	**20**	**19**	**19**	**23**	**23**	22
	Commercial	**41**	**41**	**41**	**42**	**42**	**42**	**41**	**42**	41
	Worker's Compensation	**2**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	2
	Self-pay/uninsured	**4**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	4
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

ii. Medical clinics payer mix

Based on a three-year average, four of every five visits to St. Mary's Hospital medical clinics were Medicaid covered or self-pay or uninsured, 14% of the visits were commercially-covered and 7% were covered by Medicare (Table 37). An overwhelming majority of visits to the Children's Health and Dental clinics were Medicaid covered, while family health has seen a sharp rise in self-pay or uninsured visits for family health care.

Table 37: St. Mary's Hospital's Outpatient Medical Clinics Payer Mix, FYs 2004 - 2006

		St. Mary's Hospital			
Clinic Services	Primary Payer	FY 2006	FY 2005	FY 2004	3-yr Average
Family Health	Medicare	17%	14%	13%	14%
	Medicaid	58%	69%	73%	69%
	Commercial	11%	12%	10%	11%
	Self-pay	14%	5%	4%	6%
	Total	**100%**	**100%**	**100%**	**100%**
Children's Health	Medicare	0%	0%	0%	0%
	Medicaid	86%	83%	83%	83%
	Commercial	11%	15%	15%	14%
	Self-pay	3%	2%	2%	2%
	Total	**100%**	**100%**	**100%**	**100%**
Dental	Medicare	0%	0%	0%	0%
	Medicaid	96%	66%	66%	73%
	Commercial	3%	28%	28%	22%
	Self-pay	1%	6%	6%	5%
	Total	**100%**	**100%**	**100%**	**100%**
Clinic Total	**Medicare**	**6%**	**7%**	**7%**	**7%**
	Medicaid	**78%**	**73%**	**76%**	**75%**
	Commercial	**10%**	**15%**	**14%**	**14%**
	Self-pay	**6%**	**4%**	**4%**	**4%**
	Total	**100%**	**100%**	**100%**	**100%**

The Waterbury Hospital medical clinics payer mix is similar to St. Mary's Hospital's, primarily covered by Medicaid or self-pay or uninsured (Table 38).

Table 38 : Waterbury Hospital Outpatient Medical Clinics Payer Mix, FYs 2004 – 2006

Clinic	Primary Payer	Waterbury Hospital			
		FY 2006	FY 2005	FY 2004	3 Yr Average
Chase Outpatient Center	Commercial	13%	9%	10%	11%
	Medicaid	54%	52%	54%	54%
	Medicare	24%	26%	25%	25%
	Self-pay/Uninsured	10%	12%	10%	11%
	Worker's Compensation	0%	0%	0%	0%
	Total	**100%**	**100%**	**100%**	**100%**
HIV Clinic	Commercial	20%	22%	31%	23%
	Medicaid	50%	44%	45%	47%
	Medicare	15%	14%	19%	16%
	Self-pay/Uninsured	15%	19%	5%	15%
	Worker's Compensation	0%	0%	0%	0%
	Total	**100%**	**100%**	**100%**	**100%**
Clinic Total	**Commercial**	**13%**	**10%**	**11%**	**12%**
	Medicaid	**54%**	**52%**	**54%**	**53%**
	Medicare	23%	25%	24%	**24%**
	Self-pay/Uninsured	**10%**	**13%**	**10%**	**11%**
	Worker's	**0%**	**0%**	**0%**	**0%**
	Total	**100%**	**100%**	**100%**	**100%**

5.0 Financial status of the hospitals at the end of FY 2006

Although by the end of FY 2006 St. Mary's Hospital decreased its operating losses, it continued to operate at a deficit, (3.7%) in FY 2006 compared to (10.02%) in FY 2005, (Table 1). Operating loss, for Waterbury Hospital more than tripled from the year before. For both hospitals, expenses continue to exceed revenues and since patient care is the primary source of operating revenue, the cost and the payer mix are critical to the bottom line.

Revenue from government payers (Medicare and Medicaid) to the two hospitals have dropped to 59% in FY 2006 while costs for patients covered by these payers continue to account for about 64% the costs of providing care (Table 39). Government underpayments to the hospitals are augmented by little or no revenues from self-pay patients who account for 2% of the cost of care. Revenues from patients covered by commercial and workers compensation payers although more than cover the costs of caring for those patients (about 41% versus 35% respectively) is still insufficient to make up for the deficit from government payers.

Table 39: Financial profile of St. Mary's Hospital and Waterbury Hospital, FYs 2004 – 2006

	St. Mary's Hospital*			Waterbury Hospital		
Financial Statistics	2006	2005	2004	2006	2005	2004
Net Assets						
Hospital	($136,000)	$23,760,000	$26,430,000	$124,628,134	$126,535,925	$119,504,105
Health System	$1,424,000	$8,469,000	$16,197,000	$163,330,870	$166,079,218	$158,400,874
Hospital Net Revenue Payer Mix*						
Medicare	45%	46%	46%	45%	46%	45%
Medicaid	14%	14%	14%	12%	17%	14%
Commercial	37%	36%	37%	38%	34%	37%
Workers Compensation	4%	3%	3%	4%	1%	3%
Self Pay	0%	0%	0%	0%	2%	0%
	100%	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Cost Payer Mix*						
Medicare	44%	44%	44%	46%	46%	46%
Medicaid	20%	19%	19%	17%	18%	18%
Commercial	31%	33%	33%	34%	33%	33%
Workers Compensation	2%	2%	2%	1%	1%	1%
Self Pay	2%	2%	2%	2%	2%	2%
	100%	**100%**	**100%**	**100%**	**100%**	**100%**
Financial Indicators						
Current ratio	0.8	1.96	1.78	2.03	2.15	1.93
Days of expenses in accounts payable	72	71	69	42	47	56
Days cash on hand	1	3	5	20	34	42
Days of revenue in accounts receivable	38	48	60	49	42	37
Equity financing ratio	(13%)	3%	7%	35%	37%	36%

Source: *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2005, the hospitals' Audited Financial Statements 6 & *data submitted by the hospitals in response to the investigation.*

For consecutive years both hospitals experienced negative operating margins, a sign of financial distress. This is more apparent with St. Mary's Hospital whose rather low current liabilities to current asset ratio, 0.8 in FY 2006, put the hospital at a higher risk for technical insolvency[13] . The hospital's cash flow position worsened with the amount of cash on hand to meet its short-term obligations during the year dropping from three days in FY 2005 to one day in FY 2006. The median number of days of cash on hand for the state and the nation in FY 2005 were 37.6 and 25.8 days respectively and an increasing trend is more favorable. To improve cash flow, the hospital shortened the average time it took to collect revenues from billed patients by ten days down to 38 days but that was not enough to improve the average time it took to pay creditors, which increased by one day up to 72 days.

Over the last three years, Waterbury Hospital has experienced deterioration in its cash flows; the hospital's days of cash on hand have reduced from 42 days to 20 days, which is below state and national medians. This may relate to the fact that it took the hospital seven days more to collect revenues from billed patients on average, and it paid its creditors five days earlier than the year prior. However, Waterbury Hospital is at very low risk of technical insolvency indicated by its current assets to current liabilities ratio in FY 2006 of 2.03 which is above the median for the state and nation.

Appendix A

C.G.S. §19a-633

Investigative powers. The commissioner or any agent authorized by him to conduct any inquiry, investigation or hearing under the provisions of this chapter, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the office, the commissioner or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to him by the commissioner or his authorized agent or to produce any records and papers pursuant thereto, the commissioner or his agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

Appendix 1: Saint Mary's Hospital Licensed and Staffed Beds by Service Line, FYs 2004 - 2006

Service Line	Licensed Beds	Staffed Beds				% of Licensed Beds Staffed in FY 2006
		FY 2005	FY 2005	FY 2006	3-Yr Average	
Medical/Surgical	228	105	102	102	103	46%
OB/GYN	32	31	31	31	31	97%
Psychiatry	20	12	12	12	12	60%
Critical Care	55	43	35	35	38	78%
Pediatrics	12	10	10	10	10	83%
Total	**347**	**201**	**190**	**190**	**194**	**58%**
Total Bassinets	**32**	**32**	**32**	**32**	**32**	**100%**

Appendix 2: Waterbury Hospital Licensed and Staffed Beds by Service Line, FYs 2004 - 2006

Service Line	Licensed Beds	Staffed Beds				% of Licensed Beds Staffed in FY 2006
		FY 2006	FY 2005	FY 2005	3-Yr Average	
Medical/Surgical	251	155	155	147	152	62%
OB/GYN	32	31	32	32	32	97%
Psychiatry	30	30	30	30	30	100%
Critical Care	20	20	20	20	20	100%
Pediatrics	24	10	10	10	10	42%
Total	**357**	**246**	**247**	**239**	**244**	**69%**
Total Bassinets	**36**	**36**	**36**	**36**	**36**	**100%**

Appendix 3: Saint Mary's Hospital Acute Care Discharges by Service Line, FYs 2004 - 2006

	Discharges				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
Medical	6,000	5,702	5,467	**5,723**	5	4	9
Surgical	3,320	3,403	3,308	**3,344**	-2	3	0
Behavioral Health	602	590	574	**589**	2	3	5
Maternity/Pediatrics	3,044	2,570	2,739	**2,784**	18	-6	10
Total	**12,966**	**12,265**	**12,088**	**12,440**	6	1	7

Appendix 4: Waterbury Hospital Acute Care Discharges by Service Line, FYs 2004 - 2006

	Discharges				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
Medical	6,546	6,861	6,588	**6,665**	-5	4	-1
Surgical	4,228	4,124	4,044	**4,132**	3	2	4
Behavioral Health	936	1,131	1,076	**1,048**	-17	5	-15
Maternity/Pediatrics	2,886	3,372	3,379	**3,212**	-14	0	-17
Total	**14,596**	**15,488**	**15,087**	**15,057**	**-6**	**3**	**-3**

Appendix 5: Saint Mary's Hospital Acute Care Days by Service Line, FYs 2004 - 2006

	Days				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 yr Average	06/05	05/04	06/04
Medical	29,890	27,678	26,297	**27,955**	8	5	12
Surgical	18,272	16,931	17,307	**17,503**	8	-2	5
Behavioral Health	3,864	3,709	3,588	**3,720**	4	3	7
Maternity/Pediatrics	7,966	6,781	7,008	**7,252**	17	-3	12
Total	**59,992**	**55,099**	**54,200**	**56,430**	**9**	**2**	**10**

Appendix 6: Waterbury Hospital Acute Care Days by Service Line, FYs 2004 - 2006

	Days				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 yr Average	06/05	05/04	06/04
Medical	33,582	34,054	32,532	**33,389**	-1	5	3
Surgical	21,654	19,414	20,525	**20,531**	12	-5	5
Behavioral Health	7,342	8,184	7,776	**7,767**	-10	5	-6
Maternity/Pediatrics	7,836	9,188	8,972	**8,665**	-15	2	-14
Total	**70,414**	**70,840**	**69,805**	**70,353**	**-1**	**1**	**1**

Appendix 7: Case Mix Index for St. Mary's and Waterbury Hospitals, FY 2003 - 2005

	FY 2006	FY 2005	FY 2004	FY 2003
St. Mary's	-	1.3577	1.3576	1.3733
Waterbury	-	1.3534	1.3848	1.4015

Source: *OHCA Hospital Budget System*
[1] Not yet available to OHCA.
Case mix index - measures the relative cost of treating patients at a hospital, the average cost is 1.0.

Appendix 8: Saint Mary's Hospital Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 – 2006

	Gain or Loss Per Discharge/Case ($)				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	69	431	617	**364**	-84	-30	-790
Surgical	(2,809)	(1,493)	(1,550)	**(1,947)**	88	-4	45
Behavioral Health	(2,543)	(2,162)	(1,594)	**(2,107)**	18	36	37
Maternity/Pediatrics	(561)	(1,275)	(1,298)	**(1,022)**	-56	-2	-131
Total	(937)	(585)	(515)	**(684)**	60	14	45

Appendix 9: Waterbury Hospital Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 – 2006

	Gain or Loss Per Discharge/Case ($)				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	(308)	(245)	76	**(160)**	25	-422	125
Surgical	(1,135)	(797)	(278)	**(743)**	42	187	75
Behavioral Health	(3,021)	(1,618)	(1,407)	**(1,964)**	87	15	53
Maternity/Pediatrics	(1,040)	(376)	(627)	**(663)**	177	-40	40
Total	**(866)**	**(521)**	**(282)**	**(553)**	66	85	67

Appendix 10: St. Mary's Hospital Top Ten Principal Reasons for Emergency Department Treated and Discharged Visits, FYS 2004 – 2006q1q2

ICD-9-CM Diagnosis Code	Code Description	FY 2006	FY 2005	FY 2004
465.9	Acute upper respiratory infections, unspecified site, not otherwise specified (NOS)	1,069	1,406	1,364
382.9	Otitis Media, NOS	832	1,590	1,458
34	Strep sore throat	637		
V58.3	Attending-surgical dressing/suture	617	1,050	862
79.99	Viral infection, NOS	595	1,010	1,096
462	Acute pharyngitis	529	809	760
599	Urinary tract infection, NOS	426	842	840
789	Abdominal Pain, Unspecified site	419		
493.92	Asthma NOS with acute exacerbation	409	868	794
786.59	Chest Pain Nec	406	846	772
847	Sprain Of Neck			818
786.5	Chest Pain NOS		867	797
784	Headache		876	
	Top Ten Total	**5,939**	**10,164**	**9,561**
	% of ED Treated & Discharged	**10%**	**18%**	**18%**

Appendix 11: Waterbury Hospital Top Ten Primary Reasons for Emergency Department Treated and Discharged Visits, FYs 2004 - 2006

ICD-9-CM Diagnosis Code	Diagnosis Description	FY 2006	FY 2005	FY 2004
789	Abdominal pain unspecified site	714	1,512	1,377
382.9	Otitis media NOS	519	1,008	1,072
780.6	Fever	502	950	844
786.5	Chest Pain NOS	493	932	834
465.9	Acute URI NOS	390	629	663
462	Acute pharyngitis	346		
786.59	Chest pain NEC	338	775	737
883	Open wound of finger	296	730	674
845	Sprain of ankle NOS	276	654	
784	Headache	275	638	
847.2	Sprain lumbar region			640
847	Sprain of neck		677	836
490	Bronchitis NOS			657
	Top Ten Total	**4,149**	**8,505**	**8,334**
	% of ED Treated & Discharged	**19%**	**19%**	**19%**

Appendix 12: Waterbury Hospitals Top Ten Primary Reasons for Emergency Department Treated and Admitted to Acute Care, FYs 2004 - 2006

ICD-9-CM Diagnosis Code	Diagnosis Description	FY 2006	FY 2005	FY 2004
486	Pneumonia	658	528	514
428	Congestive heart failure	517	455	377
786.59	Other chest pain	304	307	246
427.31	Atrial fibrillation	297	251	193
414.01	Coronary atherosclerosis	304	178	168
410.71	Subendocardial infarction	247	254	278
38.9	Unspecified septicemia	258		
518.81	Acute respiratory failure	256	193	150
599.0	Urinary tract infection, site not specified	262	224	204
780.2	Syncope and collapse	263		
276.5	Volume depletion		250	242
491.21	Obstructive chronic bronchitis with acute exacerbation			224
584.9	Acute renal failure, unspecified		173	
Total		3,366	2,813	2,596

Source: *OHCA Acute Care Discharge Database*

[1] *Snapshot: Connecticut's Health Insurance. Results of the Office of Health Care Access 2004 Household Survey. January 2005.*
[2] *Who are the Uninsured? Characteristics of Uninsured Workers in Connecticut.* Office of Health Care Access. January 2003.
[3] *Rising Acute Care Hospitals Inpatient Charges – FYs 1991 – 1999.* Office of Health Care Access. June 2001
[4] *Studying Health Care Utilization in Connecticut: Report to the General Assembly.* Office of Health Care Access. June 2006.
[5] Minorities include Blacks, American Indians or Eskimos or Aleuts, Hawaiian or Pacific Islanders, Asians, other non-whites and Hispanics or Latinos of any race.
[6] *Studying Health Care Utilization in Connecticut: Report to the General Assembly.* Office of Health Care Access. June 2006.
[7] *Snapshot: Connecticut's Health Insurance. Results of the Office of Health Care Access 2004 Household Survey. January 2005.*
[8] *Databook - Preventable Hospitalizations in Connecticut: Assessing Access to Community Health Services, FYs 2000 - 2004.* Office of Health Care Access. September 2005.
[9] *Health Care for Connecticut's Underserved Populations.* Connecticut Department of Public Health. November 2005.
[10] Department of Mental Health and Addiction Services (DHMAS) mental health service area which comprises of the towns of Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester, Wolcott, and Woodbury.
[11] *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children* .Submitted to the General Assembly. January 2006.
[12] *Studying Health Care Utilization in Connecticut: Report to the General Assembly.* Office of Health Care Access. June 2006.
[13] *Almanac of Hospital Financial and Operating Indicators, A comprehensive benchmark of the nation's hospitals.* Ingenix 2007.

Attachment B

State of Connecticut

THE CHARTIS GROUP, LLC. REPORT

Docket Number 06-30760-VST

Cristine A. Vogel
Commissioner
Office of Health Care Access

St. Mary's Hospital (SMH) and Waterbury Hospital (WH) jointly contracted with The Chartis Group, LLC. to conduct a market overview, a financial review and community needs assessment and present options in the planning efforts to integrate the hospitals.

The consultants projected the financial impact of different levels of possible integration:

Level 1:	Administrative and Operational Support Integration only
Level 2:	Limited Clinical Integration and Level 1
Level 3:	Full Administrative and Clinical Integration

The consultant's model included integration expenses that would be necessary depending on the level of integration required. In summary, these expenses related to cost associated with:

A. Integration Costs: consulting and legal fees, public relations costs, reduction in workforce severance, etc.

B. IT Platform Alignment: Cerner rollout to SMH, fiber optic cable linkage, PACs, telecommunication system integration, etc.

C. Facility Renovation: Emergency Department, inpatient unit expansion, outpatient facilities, etc.

With the assumptions above, the consultants then estimated costs for each level of integration over 5 years:

	Level One ("Millions")	**Level Two** ("Millions")	**Level Three** ("Millions"
A. Affiliation Costs	$ 12.0	$ 17.0	$ 25.0
B. Technical Costs	$ 12.2	$ 12.2	$ 12.2
C. Facilities Costs	$ 1.0	$ 3.9	$ 62.2
	$ 25.2	**$ 33.1**	**$ 99.4**

All levels of integration show a positive financial gain 5 years out. There would be a significant spend down or depletion of Waterbury Hospital cash reserves to facilitate the affiliation. Therefore, WH would be at risk of violating some of its bond covenants and possibly alter its credit profile and its future access to capital.

Summary of Consultant's report:

- SMH is cash flow negative, has a drained balance sheet and is outside its Bond Covenants
- WH has a stronger Balance Sheet but faces income and cash flow challenges that will make it increasingly difficult to fund future capital requirements
- According to the report, it may take more than 10 years to get to the point where the combined entity could afford to build a new combined hospital
- A closer affiliation between WH and SMH can yield significant cost savings opportunity and long term financial benefit to the region's health care delivery system
- While full clinical integration (Level 3) might be too costly in the near term, Level 1 and Level 2 can provide ample net cash flow to stabilize operations and position the delivery system to move toward full clinical integration in the future
- SMH and WH have internal issues that would need to be addressed, such as: Catholic and Secular organizations, WH has a unionized workforce, SMH liabilities, and a general cultural divide between the two organizations.

December 11, 2006

Cristine A. Vogel, Commissioner
State of Connecticut, Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Vogel:

Thank you for inviting StayWell Health Center to respond to the recent Draft Study that was completed on the two hospitals in Waterbury. We agree that there are some concerns with the structure of healthcare that impact our community. StayWell is committed to being a part of the solution so that our patients and our community can continue to have quality care that is accessible.

In the past, StayWell has partnered with both hospitals in many successful projects. Most recently we have been working on an integrated network of services for uninsured adults that includes enrollment in Pharmacy Assistance Programs, Linkage with Primary Care, Medicaid Eligibility Screening, Application Assistance and the pursuit of an Electronic Health Record.

However, we want to alert you to the many barriers to providing services that StayWell contends with because they will not make it easy to resolve the community-based issues of access that the Study discusses.

- We have difficulty getting access to Specialists who are not interested in seeing our patients. The low reimbursement rates for Title 18 and Title 19 for non-community health center providers has a trickle down effect on our patients. Not only is this barrier influenced by low reimbursement rates, but when patients have delayed care they become more complicated to manage and pose a greater malpractice risk. At StayWell, we repeatedly encounter patients who have suffered poorer outcomes either due to the lack of specialty access or due to a delay in seeking/receiving primary care because they were uninsured.

- StayWell has a base of $1 million in federal support through HRSA. Other community health centers on average are funded at a significantly higher amount. Federal support has not kept pace with the rapid growth in its client base that StayWell has experienced. In fiscal year 2000, StayWell provided 14,856 health care visits. Six years later, in fiscal year 2006, we provided 55,687 visits, a growth of 275%. StayWell employs 110 health professionals to care for these patients.

80 Phoenix Avenue ✝ Waterbury, CT 06702 ✝ Tel: (203) 756-8021 ✝ Fax: (203) 596-9038

- StayWell does receive funding from the State of Connecticut to assist with providing services to the uninsured. StayWell receives approximately $118,000 from the Department of Public Health on an annual basis to cover costs associated with the uninsured in the Adult Medicine and Dental Departments. This has been reduced over the years with a loss of over $100,000 to cover the costs of Pediatric uninsured services a few years ago. With our uninsured rate rising to 20% of all patient visits, this loss has been a struggle. Again, it is our understanding that our DPH funding for services to the uninsured is much lower than our colleagues throughout the State of Connecticut.

- There are commonalities in the struggles that our healthcare organizations face on a daily basis, primarily staffing. With the shortage in qualified nurses, we are frequently competing for staff. We have seen this to be the case for physicians also. Hiring culturally competent staff is always a struggle and then unfortunately added to the existing community shortages. Ultimately, staffing shortages impact access to care when special outreach services or walk-in hours need to be suspended due to inadequate staff to assign.

Thank you in advance for your consideration of the above-mentioned concerns that must be taken into account when designing a solution. Again, we look forward to continued conversation that will result in a solution for our patients and community.

Respectfully submitted,

Donald J. Thompson, MPS
President/CEO

cc: Robert Ritz
John Tobin
John Blair
Susan Cole England
Karen Roberts

State of Connecticut

HOSPITAL CLOSURES AND MERGERS

IN CONNECTICUT

Docket Number 06-30760-VST

Cristine A. Vogel
Commissioner
Office of Health Care Access

Attachment D

In 1990 Connecticut had 36 acute care general hospitals – today there are 30. The state has experienced the similar national trend with the decreasing number of acute care hospitals. The primary drivers of these closures and mergers are related to reimbursement, competition and shifting population demographics.

After reviewing the state's closures and mergers, it was apparent that each circumstance was different depending upon the financial strengths and weaknesses of the hospitals involved. In all of the mergers (in the cities of Bridgeport, Hartford and Meriden) one hospital was financially capable of absorbing the debt of the less viable hospital; and in no circumstances was the State of Connecticut financially responsible for the merger or closure activity.

Connecticut has experienced 6 mergers; one closure of a small rural community hospital; one acquisition and conversion of a small non-profit to the state's only for-profit hospital. The construction of a new children's hospital and a 94-bed community hospital were both results of mergers. Table 1 provides an overview of the closure and merger activity.

Table 1. Hospital Closures and Mergers in Connecticut

Year	Activity	Surviving Entity	Number of Licensed Acute-Care Hospitals
1990			36
1991	Meriden-Wallingford Hospital merges with WWII Memorial Hospital to form Veterans Memorial Medical Center	Veterans Memorial Medical Center	35
1993	Park City Hospital merges with Bridgeport Hospital	Bridgeport Hospital	34
1995	Mount Sinai Hospital merges with Saint Francis Hospital and Medical Center	Saint Francis Hospital and Medical Center	33
1996	Connecticut Children's Medical Center opens (consolidating services previously provided at three hospitals - Hartford, John Dempsey and Newington Children's Hospital) and succeeding Newington Children's Hospital	Connecticut Children's Medical Center	33
1997	Bankruptcy of Winsted Hospital	Winsted Health Center	32
1998	MidState Medical Center opens as successor to Veterans Memorial Medical Center	MidState Medical Center as successor to VMMC	32
1998	Saint Joseph's Hospital merges with Stamford Hospital	Stamford Hospital	31
2002	Not-for-profit Sharon Hospital acquired by for-profit Essent Healthcare (CT's first for-profit acute care hospital)	Sharon Hospital	31
2006	New Britain Hospital merges with Bradley Memorial Hospital	The Hospital for Central Connecticut	30

The one merger that closely resembles the circumstances with St. Mary's Hospital and the Waterbury Hospital would be the merger of Park City Hospital and Bridgeport Hospital. Below is a brief summary of facts:

Merger of Park City Hospital and Bridgeport Hospital

On March 30, 1993, OHCA issued a decision which authorized the merger of Park City Hospital into Bridgeport Hospital, with Bridgeport Hospital being the surviving entity.

The projects total capital expenditure was $14,327,000 plus $1,561,000 in capitalized financing, for a total capital expenditure of $15,888,000. The $14,388,000 Park City Hospital expenditure component was financed through CHEFA revenue bonds and the remaining $1,000,000 was equity-financed from internally generated funds.

Park City Hospital's Reasons for Merging:

- financial condition was negatively impacted by low and declining utilization of inpatient services
- inability to compete on services
- unable to renegotiate outstanding loan obligations or obtain new sources of capital
- reported long term debt payable of $810,777 and total assets of $23,547,109

Outcome of merger:

- Park City Hospital converted to an inpatient/outpatient rehabilitation center that provided inpatient psychiatric services (eventually relocated to Bridgeport Hospital)
- Park City Hospital's emergency services were replaced with primary care/walk-in center
- all acute care services provided at Park City Hospital (with the exception of ambulatory surgery) would be provided at Bridgeport Hospital site
- the merger resulted in the termination of 194 acute care beds

STATE OF CONNECTICUT

Report of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Group

March 2007

Prepared for:

Cristine A. Vogel, Commissioner
Office of Health Care Access

I. Background

In January 2006, the *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children* was issued. The report was prepared in response to Public Act 05-280, "An Act Concerning the Expenditures of the Department of Social Services." The report examined the challenges faced by the 31 acute care hospitals in Connecticut in providing inpatient behavioral health services to pediatric[1] patients, particularly in Mental Health Region 5 (Region 5). Currently, statewide only four of the hospitals have inpatient psychiatric units for children (ages 0 to 12) and six for adolescents (ages 13 to 17). Although not all hospitals have inpatient pediatric behavioral health services, hospitals attempt to accommodate these pediatric patients either in other units within the hospital or transfer them to other facilities for inpatient care.

The committee was to focus on the existing situation in Region 5 which has six acute care hospitals, Charlotte Hungerford, New Milford, Sharon, Danbury, St. Mary's and Waterbury, but only five beds for adolescent behavioral health patients at Waterbury Hospital and none at all for children in any of the hospitals (see Table 1). Also, there are no freestanding psychiatric hospitals in the region. According to the committee's report, in 2004, at least 200 the pediatric patients from the region had to access needed acute inpatient psychiatric care outside the region.

Table 1: CT acute care pediatric behavioral health beds, FY 2004

	# of Operational Beds					
Acute Care Hospitals	Age 0 - 12	Age 13 - 17	Swing beds	Age 0 - 17	Location	Region
Hospital of Saint Raphael	10	5	5	20	New Haven	2
Yale New Haven Psychiatric Hospital	15	14	0	29	New Haven	2
St. Francis Medical Center[2]	12	8	0	20	Hartford	4
Hartford/Institute of Living/CT Children's	9	13	0	22	Hartford	4
Manchester Hospital[3]	0	10	0	10	Manchester	4
Waterbury Hospital	0	5	0	5	Waterbury	5
Sub-Total	**46**	**55**	**5**	**106**		
Psychiatric Hospitals						
Public						
Riverview Children & Youth[4]	-	-	85	85	Middletown	2
Sub-Total	**0**	**0**	**85**	**85**		
Free-standing						
Hall-Brooke Behavioral Health Services	-	-	20 - 34	20 – 34	Westport	1
Silver Hill Hospital	0	10	0	10	New Canaan	1
Natchaug Hospital	6	12	3	21	Mansfield	3
Stonington Institute	0	4	0	4	N. Stonington	3
Sub-Total	**6**	**26**	**23 - 37**	**55 – 69**		
Statewide	52	81	113 - 127	246 - 260		

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Table 2, page 10.*
[1] Hospitals swing beds between the two age groups on as needed basis.
[2] Physical capacity is 23 beds.
[3] Survey was not administered to hospital.
[4] CT Department of Children and Families (DCF) provided the information; the facility has 12 additional sub-acute care beds.

[1] Under 18 years old.

In accordance with Public Act 05-280, the committee's report contains recommendations concerning the expansion of licensed hospital psychiatric inpatient bed capacity for children in Region 5. These recommendations are:

1. *Increase the number of acute care general hospital and/or psychiatric hospital beds and Psychiatric Residential Treatment Facility (PRTF) beds for children and adolescents in Region 5 based on the process outlined in Recommendation # 2.*

2. *The commissioner or designee of the Office of Health Care Access (OHCA) will convene an implementation group including the six general hospitals in Region 5, other behavioral health service providers to Region 5 residents under the age of 18, and representatives of state agencies for input on the appropriate number and location of beds. Execution of the group's proposal(s) will be subject to Certificate of Need (CON) authorization.*

To fulfill these recommendations, the Office of Health Care Access established an Implementation Group consisting of representatives of the six general hospitals in the region and of the Department of Children and Families (DCF), the Department of Social Services, Wellspring Foundation, the Child Guidance Clinic of Waterbury and the Northwest Center for Family Services and Mental Health (see Attachment 1).

The Implementation Group, which met three times during the summer and autumn, reviewed the most current pediatric inpatient behavioral health utilization data available to develop recommendations for the region. This report presents the recommendations about the appropriate number and locations of acute care, PRTF and emergency crisis stabilization beds needed in the region to facilitate patient access and transfer to appropriate levels of care and reflects the opinion of the majority of the group.

II. Implementation Group Recommendations and Rationale

Recommendation 1: Any Certificate of Need application for adding to behavioral health pediatric beds in Region 5 must include a plan for coordinating proposed additions with existing community-based services.

The overriding concern of the group is that an evaluation to establish the appropriate number of acute care beds should be system-based and not done in a vacuum. The behavioral health system includes emergency, acute and step down levels of care, all of which needed to be evaluated concurrently and any changes to be implemented should be coordinated with existing community-based services.

Recommendation 2: An additional 20 to 30 acute care general hospital and/or psychiatric hospital beds are required in Region 5. In order to provide developmentally appropriate care for children and adolescents, the additional beds should be allocated to two discrete units, one for children (up to 12 years old) and one for adolescents (13 – 18 years old).

According to the Committee's January 2006 report, there are 2.1 acute care pediatric behavioral health beds available per 10,000 residents under age 18 in Connecticut, but only 0.3 per 10,000 for the same age cohort in Region 5 (see Table 2). This demonstrates that Region 5 has substantially lower number of beds available for its pediatric population than the state in general. As a result, hospitals in the region admit children needing inpatient behavioral health services to general pediatric and adolescent units and adolescents to adult psychiatric and medical/surgical units; and the remaining are transferred or referred to hospitals located elsewhere in Connecticut or out-of-state. Currently, about one-half of the pediatric patients transferred out-of-state for behavioral health services are from Region 5. Area hospitals transferred one-third of pediatric patients from the region to other acute care providers in Connecticut for acute behavioral health treatment.

Table 2: Pediatric acute care behavioral health bed availability

Geographical Location	Regions	Acute Care Beds*	% Share	Bed per 10,000 of child population
Southwest	1	44	25%	2.6
South Central	2	49	28%	2.6
Eastern	3	25	14%	2.6
North Central	4	52	30%	2.2
Northwest	5	5	3%	0.3
Statewide		**175**	**100%**	**2.1**

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Table 3, page 11.*

* Includes beds in acute care psychiatric units and freestanding psychiatric hospitals.

Patients receiving behavioral health treatment benefit most when their families are involved. Hence, additional acute care beds should be located in the region to improve families' ability to participate in care. In the absence of a state adopted standard bed need methodology, the group applied the statewide standard of 2.1 beds per 10,000 to the pediatric population of Region 5, of 149,927 based on Census 2000, to determine the maximum number of beds the area needs. Based on this methodology, there should be up to 31 beds in total in the region, or about 26 new beds given that five already exist in Waterbury. According to the experts in the group, a 10 to 15-bed unit is the most efficient and clinically appropriate size for an acute care behavioral health unit. The treatment of children and adolescents in the same milieu is developmentally inappropriate and may be counter-therapeutic. Consequently, the group recommends establishing two discrete units in the region, with a combined capacity of 20 to 30 new acute beds.

Recommendation 3: Locate any additional acute care pediatric psychiatric units in one of the three major population centers in Region 5; Danbury, Torrington and Waterbury.

Region 5 is a geographically large and diverse area that consists of 43 cities and towns. Table 3 is an analysis of acute care hospital Region 5 pediatric behavioral health discharges by town of origin. The data indicate that the majority of discharges and their associated patient days are from three metropolitan areas, Waterbury (27% and 33%), Torrington (8% and 12%) and Danbury (11% and 7%). In order to enhance access to acute programs, the group recommends the location of any additional programs in one of the three metropolitan areas.

Table 3: Region 5 Average Annual Acute Care Pediatric Behavioral Health[1] Discharges and Days by Town of Origin: SFYs 2004 - 2006q1-q3

	Children Ages 0 - 12	Adolescents Ages 13 - 17	Ages 0 - 17
Town of Origin	Discharges = 86	Discharges = 234	Discharges = 320
Waterbury	35%	24%	27%
Danbury	16%	9%	11%
Naugatuck	6%	7%	7%
Torrington	11%	7%	8%
Cheshire	5%	6%	6%
All other towns in region[2]	27%	48%	42%
Total	100%	100%	100%
Town of Origin	Patient Days = 1,777	Patient Days = 2,053	Patient Days = 4,330
Waterbury	47%	21%	33%
Torrington	15%	9%	12%
Cheshire	6%	10%	8%
Naugatuck	4%	10%	7%
Danbury	9%	5%	7%
All other towns in region[2]	20%	46%	34%
Total	100%	100%	100%

Source: *CT Office of Health Care Access Acute Care Discharge Database*

[1]Acute care hospitals' behavioral health discharges assigned Diagnosis Related Group (DRG) 424 to 437 or 521 to 523.

[2]For this purpose, discharges and patient days for the other 37 towns in the region were not significant individually.

Recommendation 4: Establish fifteen to twenty five Psychiatric Residential Treatment Facility (PRTF) beds in Region 5. These beds should be located in proximity to existing beds or as part of the establishment of a new program or facility, which includes acute beds.

Psychiatric residential treatment facilities (PRTFs) provide inpatient psychiatric care to Medicaid-covered patients under 21 years old. PRFTs facilitate acute care hospitals' patient "throughput" to ease system gridlock and "boarding" in the EDs.

In SFY 2004, over one-half (or 167) of acute care inpatient transfers to another type of institution were Medicaid beneficiaries who might have been better served by a step down level of care at facilities such as a PRTF or community-based alternatives;[2] this is an average of 14 patients per month. According to data from the Connecticut Behavioral Health Partnership (CT BHP) at four points in time for each month between September and November of 2006, on average 9.1 patients from the region were placed in mostly non-area PRTFs (Table 4). The highest number of patients placed within a month during the period was 11.5.

Table 4: Region 5 PRTF average admissions from September to November 2006

Region 5 Hospitals	Average # in all PRTFs	Average # in Wellspring	Average # in Non-Area PRTFs
Danbury	0.7	0.1	0.7
Charlotte Hungerford	4.0	1.5	3.0
Waterbury	4.5	2.0	3.4
St Mary's			
Total	**9.1**	**3.6**	**7.1**

Source: Department of Social Services Region 5 hospital and PRTF admits under the CT BHP between September and November 2006 taken at four points in time per month.

Within a month, an average of 1.5 patients awaited placement in a PRTF. The highest number of patients who awaited placement in the three-month period was 2.0.

In all, there was an average of 10.6 PRTF placements needed in the region during the three months. The highest number of placement needed within a month was 12.75. This means, between 50 and 60 percent of the region's acute care pediatric patients admitted during the period, required placement in a PRTF after acute care. The need for a PRTF level of care has increased with Wellspring's decision to discontinue its PRTF service in November 2006.

[2] *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children*. Submitted to the Connecticut General Assembly. January 2006. Ibid.

Emergency Crisis Stabilization Beds

In evaluating the needs of the region, the group discussed the feasibility of establishing emergency crisis stabilization beds (ESC) as part of the continuum of care. ECS beds are used for managing demand spikes, extended patient observation and minimizing "boarding" or patients waiting in the ED for more than 23 hours before admission to an inpatient bed or discharged to the community. Based on the committee's report, in FY 2004, hospitals in Region 5 evaluated 660 children and adolescents with a behavioral health diagnosis in the ED before transferring them to inpatient acute care. As many as one-quarter of those patients, waited in the ED for over 23 hours before the inpatient admission (see Table 3); [3] that is, an average of 15 boarders per month.

Table 3: Number of pediatric behavioral health patients evaluated in Region 5 Emergency Departments and length of stay in hours prior to inpatient admission, FY 2004

	Ages 0 – 12		Ages 13 – 17		Age 0 – 17	
	≤ 23 hours	> 23 hours	≤ 23 hours	> 24 hours	≤ 23 hours	> 24 hours
Charlotte Hungerford	56	6	149	32	205	38
Danbury	27	0	122	6	149	6
New Milford	2	0	8	0	10	0
Sharon	0	0	2	0	2	0
St. Mary's	0	56	0	74	0	130
Waterbury[1]	35	4	77	3	112	7
Total	**120**	**66**	**358**	**115**	**478**	**181**

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children.* Submitted to the Connecticut General Assembly. January 2006. Table 6, page 15.
[1] One adolescent outlier spent 170 hours in ED.

Assuming an average stay of 48 hours in the ED for those boarders, then the average daily census is one. According to information provided by DSS, a hospital based ED affiliated crisis unit is only economically viable if it serves more than 800 to 1,000 pediatric patients per year with an average overnight census of three or more patients. Therefore, currently there is not sufficient need to sustain a hospital based crisis stabilization unit in the region. The additional acute care and PRTF beds will be enough to handle potential demand spikes and extended stays, thus eliminate boarding.

[3] Ibid.

Attachment 1

Region 5 Pediatric Inpatient Psychiatric Services Implementation Workgroup

The membership of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Workgroup included the following persons:

1. Susan Cole, Director of Certification, Financial Analysis and Forecasting & Chair	Office of Health Care Access
2. Mark Schaefer, Ph.D., Director, Medical Policy and Behavioral Health, Medical Care Administration	Department of Social Services
3. Karen Andersson	Department of Children and Families
4. Peter Johnson, Ph.D.	Department of Children and Families
5. Dr. Charles Herrick, Medical Director, Inpatient Psychiatric Services	Danbury Hospital
6. Dr. Steven Singer, Chief of Psychiatry	Charlotte Hungerford Hospital
7. Thomas Narducci, LCSW	Charlotte Hungerford Hospital
8. Maureen Salerno, Director of Social Work	New Milford Hospital
9. Jena Brebbia, LCSW	Sharon Hospital
10. Dr. Peter Jacoby, Chairman of Emergency Services Department	St. Mary's Hospital
11. Doreen Elnitsky, Administrative Director, Behavioral Health	Waterbury Hospital
12. Tom Czarkosky, Manager, Child & Adolescent Behavioral Health Services	Waterbury Hospital
13. Gary Steck, Executive Director	Child Guidance Clinic of Waterbury
14. Herb Hall	Wellspring Foundation, Inc.
15. Donna Campbell	Northwest Center for Family Services and Mental Health

Staff to the Implementation Group

1. Olga Armah, Associate Research Analyst, Research and Evaluation	Office of Health Care Access
2. Steven Lazarus, Associate Health Care Analyst, Certification, Financial Analysis and Forecasting	Office of Health Care Access

EXHIBIT Q5-2

REPORTS BY KAUFMAN HALL AND PRICEWATERHOUSE COOPERS

Financial Plan

WATERBURY HOSPITAL

Waterbury, Connecticut / December 17, 2010

DRAFT FOR DISCUSSION
PURPOSES ONLY

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Revisions to Baseline Model

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Revisions to Baseline Model

- For the revised baseline model, PWC's estimate of a reduction in net revenue of $12.5 million in FY 2011 compared to budget has been incorporated.
- Cost reductions related to a drop in surgical cases for FY 2011 of $4.2 million (75% of the net revenue drop of $5.6 million) have also been included.
- In FY 2012, an additional $1 million has been included for additional Federal stimulus monies for Information Technology beyond the $462K included in the FY 2011 budget.

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Revised Baseline Model

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The Waterbury Hospital Revised Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$254.8	$258.1	$264.9	$273.5	$282.2	$291.4
Operating Income	----	----	----	($9.2)	($7.6)	($9.0)	($8.9)	($9.1)	($9.2)
Operating EBIDA	----	----	----	$2.2	$1.9	$2.5	$3.6	$4.6	$5.9
Excess Income	----	----	----	($3.9)	($1.6)	($3.1)	($3.2)	($3.6)	($3.8)
Cash Flow (Net Inc + Depr)	----	----	----	$5.7	$7.3	$7.3	$8.2	$9.1	$10.2
Unrestricted Cash	----	----	----	$34.7	$28.2	$22.5	$16.1	$9.2	$1.6
Total Debt	----	----	----	$20.2	$26.2	$25.7	$25.2	$24.7	$24.2
Capital Expenditures	----	----	----	$7.1	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.5%	-2.9%	-3.3%	-3.2%	-3.2%	-3.1%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.9%	0.7%	0.9%	1.3%	1.6%	2.0%
Excess Margin	3.0%	1.6%	2.3%	-1.5%	-0.6%	-1.1%	-1.1%	-1.2%	-1.3%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.6	4.1	5.3	5.9	6.4	7.1
Debt to Capitalization	36.6%	40.1%	43.1%	30.9%	37.5%	38.9%	40.4%	42.3%	44.8%
Debt to Cash Flow	----	----	----	2.7	3.3	3.1	2.7	2.4	2.2
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	171.4%	107.6%	87.3%	63.9%	37.1%	6.8%
Days Cash on Hand (days)	176.3	125.7	125.1	48.5	39.3	30.4	21.2	11.7	2.0
Days in A/R, net	47.4	45.5	45.1	45.6	45.6	45.6	45.6	45.6	45.6
Other									
Average Age of Plant	10.1	10.0	10.3	22.3	25.0	22.6	21.4	20.4	19.4
Compensation Ratio	50.9%	54.2%	49.0%	58.6%	60.3%	59.8%	59.2%	58.6%	58.0%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	74.2%	247.2%	120.0%	120.0%	120.0%	120.0%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

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Greater Waterbury Health Network, Inc. and Subsidiaries Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$259.8	$263.2	$270.1	$278.8	$287.6	$297.0
Operating Income	----	----	----	-$9.8	-$8.2	-$9.6	-$9.6	-$9.8	-$9.9
Operating EBIDA	----	----	----	$1.9	$1.7	$2.2	$3.3	$4.3	$5.5
Excess Income	----	----	----	-$3.9	-$1.0	-$2.5	-$2.6	-$3.0	-$3.2
Cash Flow (Net Inc + Depr)	----	----	----	$6.0	$8.1	$8.1	$9.1	$9.9	$11.0
Unrestricted Cash	----	----	----	$58.3	$52.5	$47.6	$42.0	$35.9	$29.1
Total Debt	----	----	----	$21.8	$27.7	$27.2	$26.7	$26.1	$25.5
Capital Expenditures	----	----	----	$5.6	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.6%	-3.0%	-3.4%	-3.3%	-3.3%	-3.2%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.7%	0.6%	0.8%	1.1%	1.4%	1.8%
Excess Margin	3.0%	1.6%	2.3%	-1.4%	-0.4%	-0.9%	-0.9%	-1.0%	-1.0%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.5	4.2	5.4	5.9	6.4	7.0
Debt to Capitalization	36.6%	40.1%	43.1%	23.8%	29.8%	30.2%	30.7%	31.3%	32.1%
Debt to Cash Flow	----	----	----	2.8	3.1	2.9	2.6	2.4	2.1
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	285.8%	193.2%	178.5%	161.0%	140.5%	116.8%
Days Cash on Hand (days)	176.3	125.7	125.1	78.8	70.8	62.2	53.5	44.4	35.1
Days in A/R, net	47.4	45.5	45.1	45.8	45.8	45.8	45.8	45.8	45.8
Other									
Average Age of Plant	10.1	10.0	10.3	22.0	24.6	22.3	21.2	20.2	19.3
Compensation Ratio	50.9%	54.2%	49.0%	58.8%	60.5%	60.0%	59.4%	58.8%	58.2%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	56.6%	241.3%	117.5%	117.8%	118.0%	118.2%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

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Productivity Improvements

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Productivity Improvements

FTE's were reduced gradually to achieve an FTE per AOB level of 4.80 by 2015 as follows:

	FTE's	FTE Change	FTE's per AOB	Compensation Ratio
2008	1,618.7		5.25	59.9%
2009	1,589.1		5.42	55.6%
2010	1,513.0		5.91	58.6%
2011 Budget	1,507.3		5.88	60.3%
2011 Revised	1,487.2	(20.1)	5.80	59.5%
2012	1,429.5	(57.7)	5.55	56.7%
2013	1,373.4	(56.1)	5.30	53.8%
2014	1,313.4	(60.0)	5.05	50.9%
2015	1,256.0	(57.4)	4.80	48.1%

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The Waterbury Hospital Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$254.8	$258.1	$264.9	$273.5	$282.2	$291.4
Operating Income	----	----	----	($9.2)	($5.5)	($0.4)	$6.2	$13.3	$20.5
Operating EBIDA	----	----	----	$2.2	$4.0	$11.1	$18.8	$27.0	$35.5
Excess Income	----	----	----	($3.9)	$0.5	$5.8	$12.8	$20.6	$29.0
Cash Flow (Net Inc + Depr)	----	----	----	$5.7	$9.5	$16.2	$24.3	$33.3	$43.0
Unrestricted Cash	----	----	----	$34.7	$30.1	$32.7	$41.7	$58.3	$82.9
Total Debt	----	----	----	$20.2	$26.2	$25.7	$25.2	$24.7	$24.2
Capital Expenditures	----	----	----	$7.1	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.5%	-2.1%	-0.1%	2.2%	4.6%	6.9%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.9%	1.5%	4.1%	6.7%	9.4%	11.9%
Excess Margin	3.0%	1.6%	2.3%	-1.5%	0.2%	2.1%	4.5%	7.0%	9.4%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.6	5.2	10.9	16.0	21.7	27.8
Debt to Capitalization	36.6%	40.1%	43.1%	30.9%	36.4%	33.3%	28.2%	22.6%	17.5%
Debt to Cash Flow	----	----	----	2.7	2.6	1.5	1.0	0.7	0.5
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	171.4%	115.0%	127.0%	165.4%	235.7%	342.3%
Days Cash on Hand (days)	176.3	125.7	125.1	48.5	42.3	45.7	58.1	81.0	114.8
Days in A/R, net	47.4	45.5	45.1	45.6	45.6	45.6	45.6	45.6	45.6
Other									
Average Age of Plant	10.1	10.0	10.3	22.3	25.0	22.6	21.4	20.4	19.4
Compensation Ratio	50.9%	54.2%	49.0%	58.6%	59.5%	56.7%	53.8%	50.9%	48.1%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	74.2%	247.2%	120.0%	120.0%	120.0%	120.0%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

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Greater Waterbury Health Network, Inc. and Subsidiaries Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$259.8	$263.2	$270.1	$278.8	$287.6	$297.0
Operating Income	----	----	----	-$9.8	-$6.1	-$1.0	$5.6	$12.6	$19.7
Operating EBIDA	----	----	----	$1.9	$3.8	$10.8	$18.4	$26.7	$35.1
Excess Income	----	----	----	-$3.9	$1.1	$6.4	$13.4	$21.2	$29.6
Cash Flow (Net Inc + Depr)	----	----	----	$6.0	$10.3	$17.0	$25.1	$34.1	$43.8
Unrestricted Cash	----	----	----	$58.3	$54.5	$57.8	$67.6	$85.0	$110.3
Total Debt	----	----	----	$21.8	$27.7	$27.2	$26.7	$26.1	$25.5
Capital Expenditures	----	----	----	$5.6	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.6%	-2.2%	-0.4%	1.9%	4.2%	6.4%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.7%	1.4%	3.9%	6.4%	8.9%	11.4%
Excess Margin	3.0%	1.6%	2.3%	-1.4%	0.4%	2.2%	4.5%	6.9%	9.3%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.5	5.2	10.5	15.2	20.3	25.9
Debt to Capitalization	36.6%	40.1%	43.1%	23.8%	29.1%	26.8%	23.3%	19.2%	15.4%
Debt to Cash Flow	----	----	----	2.8	2.5	1.5	1.0	0.7	0.6
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	285.8%	200.4%	216.8%	259.0%	332.8%	442.3%
Days Cash on Hand (days)	176.3	125.7	125.1	78.8	74.0	78.0	90.9	113.8	147.2
Days in A/R, net	47.4	45.5	45.1	45.8	45.8	45.8	45.8	45.8	45.8
Other									
Average Age of Plant	10.1	10.0	10.3	22.0	24.6	22.3	21.2	20.2	19.3
Compensation Ratio	50.9%	54.2%	49.0%	58.8%	59.7%	56.9%	54.1%	51.3%	48.6%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	56.6%	241.3%	117.5%	117.8%	118.0%	118.2%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

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Appendix

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Historical Credit Profile

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Statement of Operations

- For purposes of comparability to the rating agency benchmarks, certain revenues classified as Other Operating Revenue in the audited financial statements have been reclassified to Non-Operating Revenue.
- Specifically, Investment Related Income, Unrestricted Gifts and Bequests, and Net Assets Released from Restrictions have been moved to Non-Operating Revenue.
- Unrealized gains or losses are excluded from the Statement of Operations.

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The Waterbury Hospital Historical Credit Profile

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Year ending September 30, Actual 2008	2009	2010
Net Patient Service Revenue	$248.2	$250.1	$177.0	$235.3	$253.5	$254.8
Operating Income	----	----	----	($14.0)	($6.4)	($9.2)
Operating EBIDA	----	----	----	($2.3)	$4.7	$2.2
Excess Income	----	----	----	($8.4)	$0.5	($3.9)
Cash Flow (Net Inc + Depr)	----	----	----	$1.8	$10.1	$5.7
Unrestricted Cash	----	----	----	$31.5	$31.3	$34.7
Total Debt	----	----	----	$22.2	$20.4	$20.2
Capital Expenditures	----	----	----	$4.3	$2.0	$7.1
Profitability						
Operating Margin	2.1%	1.6%	2.3%	-5.8%	-2.5%	-3.5%
Operating EBIDA Margin	9.9%	8.1%	9.3%	-0.9%	1.8%	0.9%
Excess Margin	3.0%	1.6%	2.3%	-3.4%	0.2%	-1.5%
Debt Position						
Debt Service Coverage	3.2	2.4	3.0	0.9	3.3	2.6
Debt to Capitalization	36.6%	40.1%	43.1%	29.8%	29.3%	30.9%
Debt to Cash Flow	----	----	----	6.6	1.8	2.7
Liquidity						
Cash to Debt	117.4%	99.3%	88.2%	141.6%	153.1%	171.4%
Days Cash on Hand (days)	176.3	125.7	125.1	47.0	45.0	48.5
Days in A/R, net	47.4	45.5	45.1	55.4	46.6	45.6
Other						
Average Age of Plant	10.1	10.0	10.3	19.3	21.3	22.3
Compensation Ratio	50.9%	54.2%	49.0%	59.9%	55.6%	58.6%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	42.6%	20.7%	74.2%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

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Greater Waterbury Health Network, Inc. and Subsidiaries Historical Credit Profile

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Year ending September 30, Actual 2008	2009	2010
Net Patient Service Revenue	$248.2	$250.1	$177.0	$240.0	$258.1	$259.8
Operating Income	----	----	----	-$19.8	-$10.8	-$9.8
Operating EBIDA	----	----	----	-$7.6	$0.8	$1.9
Excess Income	----	----	----	-$14.7	-$3.8	-$3.9
Cash Flow (Net Inc + Depr)	----	----	----	-$4.2	$6.1	$6.0
Unrestricted Cash	----	----	----	$53.4	$53.1	$58.3
Total Debt	----	----	----	$27.8	$22.5	$21.8
Capital Expenditures	----	----	----	$4.3	$2.6	$5.6
Profitability						
Operating Margin	2.1%	1.6%	2.3%	-7.8%	-4.0%	-3.6%
Operating EBIDA Margin	9.9%	8.1%	9.3%	-3.0%	0.3%	0.7%
Excess Margin	3.0%	1.6%	2.3%	-5.7%	-1.4%	-1.4%
Debt Position						
Debt Service Coverage	3.2	2.4	3.0	(0.3)	1.0	2.5
Debt to Capitalization	36.6%	40.1%	43.1%	22.4%	23.4%	23.8%
Debt to Cash Flow	----	----	----	(11.1)	2.9	2.8
Liquidity						
Cash to Debt	117.4%	99.3%	88.2%	243.1%	250.5%	285.8%
Days Cash on Hand (days)	176.3	125.7	125.1	73.9	71.3	78.8
Days in A/R, net	47.4	45.5	45.1	56.1	46.7	45.8
Other						
Average Age of Plant	10.1	10.0	10.3	18.9	21.0	22.0
Compensation Ratio	50.9%	54.2%	49.0%	60.7%	56.2%	58.8%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	41.2%	25.9%	56.6%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

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Financial Plan Assumptions

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Capital Requirements ($ in thousands)

	2011	2012	2013	2014	2015	5-Year Total
Capital Uses						
P7 and OR renovations	$4,000					$4,000
Hospital capital	$4,150	$12,418	$13,727	$15,170	$16,768	$62,233
AMG capital	$245					$245
Cerner & IT capital	$5,113					$5,113
Cath lab replacement	$1,600					$1,600
	$15,108	$12,418	$13,727	$15,170	$16,768	$73,191
Strategic Investments						
CAW Practice	$4,900					
Phoenix Practice	$2,023					
Zlotoff Practice	TBD					
Wetmore Practice	TBD					
	$6,923					
Total All Capital	$22,031	$12,418	$13,727	$15,170	$16,768	$73,191
Capital Spending Ratio [A]	247.2%	120.0%	120.0%	120.0%	120.0%	139.8%

Note [A] S&P's "A-" and "BBB+" category medians for capital spending ratios are 157% and 107%, respectively.

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Baseline Volume

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2010-2015 Total Growth
New Haven County Population	854,283	853,158	852,034	847,867	848,438	848,672	849,660	850,649	851,640	852,631	853,624	0.6%
Market Use Rates (per 1,000 pop)	119	121	120	120	120	120	120	120	120	120	120	
Total Market Volume	101,249	102,967	101,907	101,409	101,477	101,505	101,623	101,741	101,860	101,978	102,097	0.6%
Waterbury Mkt Share	10.3%	9.9%	10.1%	10.8%	10.2%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	
Waterbury Inpatient Volume												
New Haven Volume	10,445	10,211	10,309	10,974	10,363	9,715	9,755	9,767	9,778	9,790	9,801	
Inmigration	3,531	3,550	3,534	3,763	3,553	3,331	3,345	3,348	3,352	3,356	3,360	
Total Admissions	**13,976**	**13,761**	**13,844**	**14,737**	**13,916**	**13,046**	**13,100**	**13,115**	**13,131**	**13,146**	**13,161**	0.9%
Annual growth		-1.5%	0.6%	6.5%	-5.6%	-6.3%	0.4%	0.1%	0.1%	0.1%	0.1%	

This results in an Average Daily Census of between 163 and 164 per year.

Outpatient visits were projected to increase 1% greater than inpatient volume, or 1.1% annually.

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Revenue Assumptions

- The following net revenue increases per year have been assumed
  - Overall Charge Increase – 6.0%
  - Medicare Inpatient – (1.1%) in 2012, .55% in 2013, .3% in 2014, .4% in 2015
  - Medicare Outpatient – 1.8% in 2012, 1.85% in 2013, 1.6% in 2014, and 1.7% in 2015
  - Medicaid – Flat
  - Blue Cross – 4% annually (7% used in budget for FY 2011)
  - Commercial – . 4% annually (7% used in budget for FY 2011)
  - Managed Care - 4% annually (7% used in budget for FY 2011)
  - Self Pay – flat
  - VNA Services – 2% annually

- An investment earnings rate of 5.0% was assumed on all available cash.

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Expense Assumptions

- Salaries were projected to increase 2.0% annually (1.5% in budget). FTE's were assumed to be 30% variable and 70% fixed with volume.
- Employee benefits were projected to remain at approximately 30% of salaries and wages over the projection period.
- Drugs were projected to increase 5% per year.
- Utilities were projected to increase 4% per year.
- Medical supplies were projected to increase 3.5% per year.
- Professional fees, purchased services, and other general expenses were projected to increase 3% per year.
- Insurance and other supplies were projected to increase 2% per year.
- Bad debt was projected to remain at about 1.9% of gross revenue over the projection period.

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Baseline Productivity

	FTE's	FTE's per AOB	Compensation Ratio
2008	1,618.7	5.25	59.9%
2009	1,589.1	5.42	55.6%
2010	1,513.0	5.91	58.6%
2011	1,507.3	5.88	57.6%
2012	1,509.5	5.86	57.3%
2013	1,511.7	5.84	56.8%
2014	1,513.9	5.82	56.2%
2015	1,516.2	5.80	55.7%

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DRAFT

Waterbury Hospital
Financial Analysis
December 2, 2010

Private and Confidential

PRICEWATERHOUSECOOPERS

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Section 1
Executive Summary

PRICEWATERHOUSECOOPERS

Executive Summary

PwC was engaged to evaluate the following:

- FY 2010 YTD Results vs. Budget
- FY 2011 Budget
- Hospital Run Rate
- Hospital Business Line Profitability / Marginal Profitability
- Initiatives Dashboards
- Leading Indicators Report

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FY 2010 Actual to Budget

	FY2010 Actual	FY2010 Budget	Variance to Budget	% Variance to Budget
Net Revenue	$ 214,025,504	$ 228,549,429	$ (14,523,925)	-6.4%
Other Operating Revenue	9,734,335	7,915,625	1,818,710	23.0%
Total Operating Revenue	223,759,839	236,465,054	(12,705,215)	-5.4%
Total Expenses	229,237,303	227,774,129	1,463,174	0.6%
Income / (Loss) from Operations	(5,477,464)	8,690,925	(14,168,389)	163.0%
Non-Operating Income	1,916,451	1,392,700	523,751	37.6%
Net Income / (Loss)	$ (3,561,013)	$ 10,083,625	$ (13,644,638)	135.3%
Statistics:				
Admissions	13,046	13,786	(740)	-5.4%
Patient Days	59,271	69,378	(10,107)	-14.6%
ALOS	4.54	5.03	(0.49)	-9.7%
OR Procedures	3,272	3,550	(278)	-7.8%
One-Day Surgery Procedures	4,504	5,272	(768)	-14.6%
Observation Cases	1,072	785	287	36.6%
Outpatient Cases	168,418	175,211	(6,793)	-3.9%
Emergency Visits	49,031	46,302	2,729	5.9%
Overtime / Doubletime Dollars	$ 2,220,682	$ -	$ 2,220,682	n/a
Temporary Help Dollars	$ 838,767	$ 171,996	$ 666,771	387.7%
Payor Mix:				
Government	65.49%	64.83%	0.66%	
Non-Government (Excluding Self Pay)	32.51%	31.92%	0.59%	
Self Pay	2.00%	3.25%	-1.25%	

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Overview of FY 2010 Financial Results

- Hospital has experienced a market share decline. FY 2010 admissions were 740 (5.4%) less than FY 2010 budget admissions
  - Orthopedic surgeons moved business to other hospitals
  - Physicians expressed frustration with newly rolled out IT processes and systems (enough to go to other hospitals)
  - Primary care physicians approached by other hospitals and ProHealth
- Actual patient days for FY 2010 were 10,107 less than the FY 2010 budget. 6,700 patient days of the budget variance are related to the FY 2010 reduction in length of stay (5.0 to 4.5); 3,300 patient days are related to reduced admissions
- FTEs per adjusted occupied bed increased from 5.17 to 6.05 (Budget vs. Actual FY2010). Staffing was not adjusted to reflect decrease in length of stay resulting from patient throughput initiatives
- $376K over budget on Accretion Expense due to previously unidentified asbestos
- Medicaid outpatient audit unfavorable impact of $1.1 million (management estimate)
- Fair Pay Workers' Compensation adjustment of receivables to 45% collectability, with an unfavorable impact of $1.8 million
- Employee benefits were over budget by $3.6 million, with $1.4 million attributable to behavioral health remaining within Waterbury Hospital instead of moving to Alliance Medical Group, $700K due to 30 FTE surplus over budget, and $700K due to post-audit adjustment to workers compensation
- Bad debt expense under budget by $8.1 million
- No adjustments were found in FY 2010 expenses

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FY 2010 Actual Compared to FY 2011 Budget

The following is the FY 2010 Actual and FY 2011 Budget as stated by Waterbury Hospital:

	FY2010 Actual	FY2011 Budget
Net Revenue	$ 214,025,504	$ 225,999,921
Other Operating Revenue	9,734,335	9,549,161
Total Operating Revenue	223,759,839	235,549,082
Total Expenses	229,237,303	231,112,610
Net Income (Loss) from Operations	(5,477,464)	4,436,472
Non-Operating Income	1,916,451	1,605,000
Net Gain (Loss)	$ (3,561,013)	$ 6,041,472

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FY 2011 Budget Overview

The following is a summary of Waterbury Hospital's FY 2011 Budget:

- Gain from operations of $4.4 million, net gain of $6.0 million
- Refinancing that increases cash by approximately $13.4 million ($8.0 million in additional borrowings, $3.4 million reduction to 55 days cash on hand requirement and $2.0 million debt service reserve fund no longer required)
- Additions to property, plant, and equipment of $15.1 million, which includes $5.1 million in Cerner and IT capital spend, $4.0 million for Pomeroy 7 and Operating Room renovations, $1.6 million for Cath Lab replacement, and $4.4 million for routine hospital capital
- Strategic investment in CAW of $2.4 million (acquisition) and $2.5 million of working capital and Electronic Medical Records costs
- Other strategic investments in Phoenix, and other practices
- Average age of plant of 25 years for the Hospital at the end of FY 2011
- Days cash on hand at 9/30/11 is 55 days
- FTEs per adjusted occupied bed increasing from FY 2009 actual level of 5.41 to 6.05 for budgeted FY 2011

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FY 2011 Significant Findings

- Proposed adjustments that would reduce net revenue by $12.5 million (these adjustments have not been reviewed with management)
- Reduction in net revenue significantly impacts cash and the hospital's ability to pay for capital expenditures and will impact bond covenants
- Preliminary 5 year capital plan (not completed, where plan stood as of 11/30/10) has approximately $88.6 million of capital needs identified. Significant operating margins will be needed to meet future capital needs. Operating margins will need to be between 4% and 5% annually for the next 5 years to achieve the $88 million of capital needs
- Replacement time is not consistently budgeted across all departments and no position control system has been maintained, this will yield unexpected variances in temporary help and overtime
- To reach 50th percentile benchmark levels, FTEs per adjusted occupied bed would need to be reduced by approximately 236 with an associated reduction in salaries and benefits of approximately $20.4 million. Approximately 25-30 of these FTEs currently exist in inpatient nursing

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Summary of Potential Adjustments to FY 2011 Budget

Net Revenue	Proposed Adjustment to Budget	Potential Volume Exposure	Total
Medicare Case Mix Index			
Acute Renal Failure Coding Change	$ (1,403,000)		$ (1,403,000)
FY 2010 Case Mix - (1.715 to 1.6956)	(723,000)		(723,000)
Decline in Surgical Cases*		$ (5,624,000)	(5,624,000)
Observation Cases (Medicare)	(595,000)		(595,000)
Fair Pay - Overstatement of Charges	295,000		295,000
Fair Pay - Adjustment to Current Payment Rates from Potential Contract Rates	(350,000)		(350,000)
Outpatient Payment Factors	(1,520,000)		(1,520,000)
Medicaid Outpatient Audit Exposure	(733,000)		(733,000)
RAC Audit Exposure (FY 2011)	(1,040,000)		(1,040,000)
Medicare Physician Payment Reduction (23% Jan - Sept)[1]	(125,000)		(125,000)
Commercial Insurance Adjustment (No Support)	255,000		255,000
Medicare Inpatient Prospective Payment System Final Rule	(273,000)		(273,000)
Length of Stay and Payor Mix	(700,000)		(700,000)
TOTAL Net Revenue Adjustment	**$ (6,912,000)**	**$ (5,624,000)**	**$ (12,536,000)**

** Estimated to be a decline of 360 orthopedic discharges based upon the latest volume trends. This translates to a potential exposure of approximately $5,624,000 (360 cases x net revenue of $15,622 per orthopedic surgical case) assuming this trend continues.*

[1] Reduced reimbursement unlikely to occur.

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FY 2010 Actual Compared to FY 2011 Budget

The following is a summary of the proposed adjustments to the fiscal year 2011 budget:

	FY2010 Actual	FY2011 Budget	Proposed Adjustments	Adjusted FY2011 Budget
Net Revenue	$ 214,025,504	$ 225,999,921	$ (12,536,000)	$ 213,463,921
Other Operating Revenue	9,734,335	9,549,161	-	9,549,161
Total Operating Revenue	223,759,839	235,549,082	(12,536,000)	223,013,082
Total Expenses	229,237,303	231,112,610	-	231,112,610
Net Income (Loss) from Operations	(5,477,464)	4,436,472	(12,536,000)	(8,099,528)
Non-Operating Income	1,916,451	1,605,000	-	1,605,000
Net Gain (Loss)	$ (3,561,013)	$ 6,041,472	$ (12,536,000)	$ (6,494,528)

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FY 2011 - October Actual to Budget

The following is a summary of the October 2010 actual to budget:

	Oct 2010 Actual	Oct 2010 Budget	Variance to Budget	% Variance to Budget
Net Revenue	$ 17,799,080	$ 18,087,868	$ (288,788)	-1.6%
Other Operating Revenue	682,013	795,767	(113,754)	-14.3%
Total Operating Revenue	18,481,093	18,883,635	(402,542)	-2.1%
Total Expenses	18,914,767	19,846,983	(932,216)	-4.7%
Income / (Loss) from Operations	(433,674)	(963,348)	529,674	55.0%
Non-Operating Income	101,733	113,750	(12,017)	-10.6%
Net Income / (Loss)	$ (331,941)	$ (849,598)	$ 517,657	60.9%
Statistics:				
Admissions	1,047	1,048	(1)	-0.1%
Patient Days	4,672	4,750	(78)	-1.6%
ALOS	4.46	4.53	(0.07)	-1.5%
Medicare CMI	1.66	1.71	(0.05)	-2.9%
OR Procedures	226	263	(37)	-14.1%
One-Day Surgery Procedures	354	367	(13)	-3.5%
Outpatient Cases	14,062	13,435	627	4.7%
Emergency Visits	4,045	3,986	59	1.5%
Payor Mix:				
Medicare	36.0%	40.3%	-4.3%	
Managed Medicare	8.9%	7.2%	1.7%	
Medicaid	11.0%	10.0%	1.0%	
Managed Medicaid	7.8%	7.3%	0.6%	
Commercial	9.7%	11.0%	-1.3%	
Managed Care	23.5%	22.1%	1.3%	
Self Pay	3.1%	2.0%	1.0%	

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Action Steps

The following are recommended priority action steps:

- Prepare and execute on action plans to mitigate market share declines
- Realign staffing and other costs to match latest length of stay and discharge volume trends
- Implement monthly financial reporting, budgeting and decision support systems; establishing accountability and alignment with a metrics driven organization
- Compile and implement a financial plan that addresses the following:
    - Days cash on hand
    - Average age of plant /other capital needs
    - Income from operations to achieve above
- Execute Cerner upgrades and module implementation
- Plan for health care reform (reductions in government payments will require hospitals to reduce operating expenses by 3-5% per year for the foreseeable future)
- Explore capital partner/affiliation/merger strategy

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Section 2
FY 2010 YTD Results vs. Budget

PRICEWATERHOUSECOOPERS

FY 2010 Actual to Budget

	FY2010 Actual	FY2010 Budget	Variance to Budget	% Variance to Budget
Net Revenue	$ 214,025,504	$ 228,549,429	$ (14,523,925)	-6.4%
Other Operating Revenue	9,734,335	7,915,625	1,818,710	23.0%
Total Operating Revenue	223,759,839	236,465,054	(12,705,215)	-5.4%
Total Expenses	229,237,303	227,774,129	1,463,174	0.6%
Income / (Loss) from Operations	(5,477,464)	8,690,925	(14,168,389)	163.0%
Non-Operating Income	1,916,451	1,392,700	523,751	37.6%
Net Income / (Loss)	$ (3,561,013)	$ 10,083,625	$ (13,644,638)	135.3%
Statistics:				
Admissions	13,046	13,786	(740)	-5.4%
Patient Days	59,271	69,378	(10,107)	-14.6%
ALOS	4.54	5.03	(0.49)	-9.7%
OR Procedures	3,272	3,550	(278)	-7.8%
One-Day Surgery Procedures	4,504	5,272	(768)	-14.6%
Observation Cases	1,072	785	287	36.6%
Outpatient Cases	168,418	175,211	(6,793)	-3.9%
Emergency Visits	49,031	46,302	2,729	5.9%
Overtime / Doubletime Dollars	$ 2,220,682	$ -	$ 2,220,682	n/a
Temporary Help Dollars	$ 838,767	$ 171,996	$ 666,771	387.7%
Payor Mix:				
Government	65.49%	64.83%	0.66%	
Non-Government (Excluding Self Pay)	32.51%	31.92%	0.59%	
Self Pay	2.00%	3.25%	-1.25%	

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Volume – Anecdotal Findings

- Inpatient discharge volume for the State of Connecticut is basically flat for FY 2010 when compared to FY 2009 (through June 30)
- Primary care physicians have been recruited/approached by other hospitals and ProHealth
- Orthopedic surgeons have moved surgical volume to other hospitals
- Some physicians have expressed frustrations with newly rolled out IT processes and systems
  - "Depart" process
  - Medication reconciliation
  - Performance improvement initiatives in perioperative services and throughout the hospital

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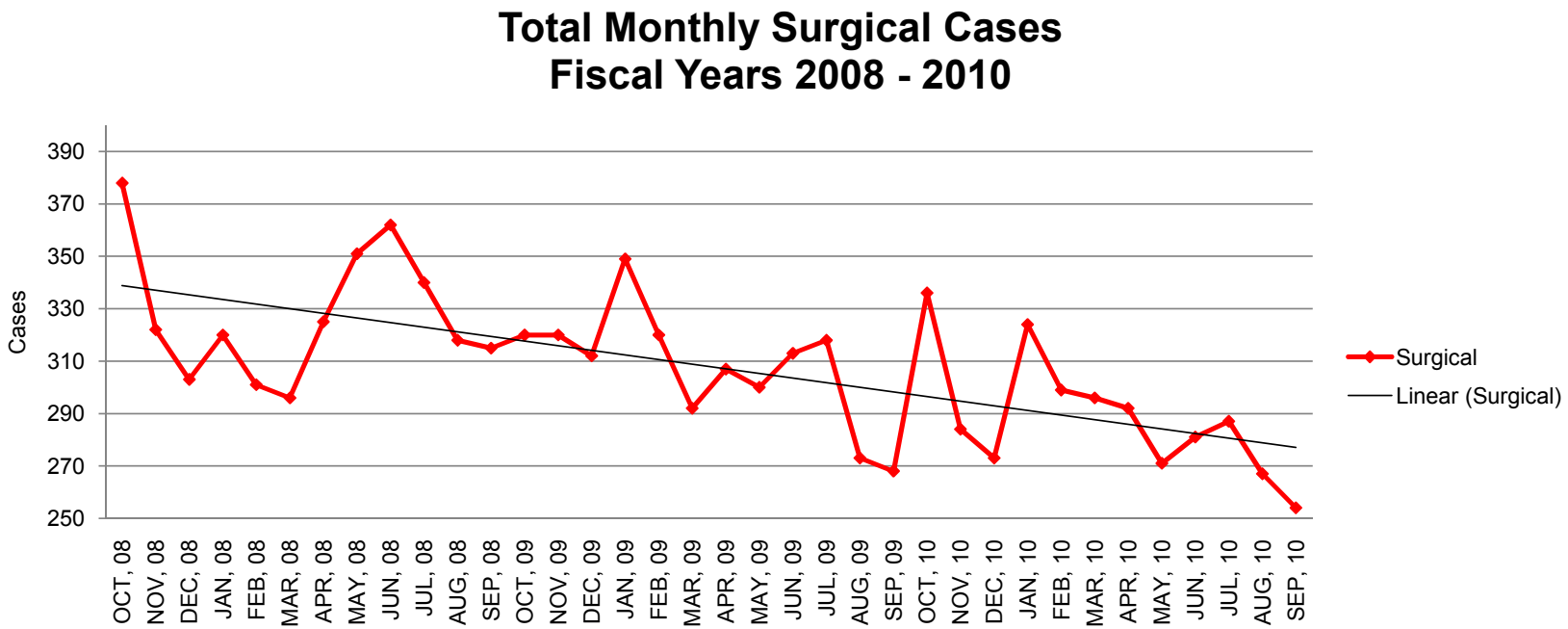
Total Surgical Cases



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Budgeted Expense Evaluation

The following actions were taken when reviewing the budgeted expenses:

- Determined the cause of the budget to actual 30 FTE variance for FY2010 and the impact of temporary help and overtime on payroll expense by cost center
- Evaluated budget to actual variances by cost center for FY2010 and corresponding actual FY2009 values and budgeted FY2011 values. All positive or negative variances over 10% were evaluated in detail to identify cause(s) of discrepancy
  - Interviewed Senior Budget Analyst to discuss discrepancies and understand cause of high dollar and/or variance expense items
- Interviewed Executive Director of Process Improvement to understand use of dashboards and progress on key cost reduction initiatives
- Evaluated yearly Cerner implementation operational and capital expenses
- Gained insight on FY2011 $2M projected medical/surgical supply expense reduction and GPO expense reductions realized in FY2010

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Expense Indicator Evaluation

Patient throughput initiatives are successful. Further FTE reductions were not reflective of decreased demand.

Indicator	FY2009 Actual	FY2010 Budget	FY2010 Actual	FY2011 Budget	Trend
Patient Days	67,682	69,378	59,271	59,378	↓
Admissions	13,928	13,786	13,046	13,100	↓
Overall Case Mix Index (CMI)	1.35	1.35	1.39	1.39	↑
Average Length of Stay (ALoS)	4.86	5.03	4.54	4.53	↓
FTEs	1,589	1,482	1,513	1,507	↓
Total Salary Spend	105,995,288	101,436,095	98,725,135	100,143,265	!
FTEs per Adjusted Occupied Bed	5.41*	5.17	5.91	6.05	↑

* Median FTEs per adjusted occupied bed for the state of Connecticut was 4.60 (FY2009). Waterbury Hospital ranked 24th out of 30 Connecticut hospitals. Solucient Action OI adjusted occupied bed 50th percentile benchmark is 5.10

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Expense Review

46 cost centers ran over budget for FTEs during FY2010:

- A total of 40 FTEs were used above budget
- 11 FTEs (28%) are attributed to unbudgeted performance improvement initiatives
- 18 FTEs (45%) are in four Nursing Units experiencing reductions in patient days
  - One of these units also had in excess of $200K in Temporary Help
  - An analysis of September 2010 performance shows these trends continuing
- The remainder are in small increments across many cost centers

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Budget to Actual Expense Variances

The following represents a sample of the causes for the budget to actual variances during FY 2010:

- *Clinical Resource and Quality Management:* $365K variance due to DPH findings
- *Employee Benefits:* $1.38M budgeted benefit reduction not realized by hospital due to behavioral health not transferring to Alliance Medical Group
- *Administrative Finance:* unbudgeted $962K a result of ED Medicaid billing for AMG
- *Ultrasound & Diagnostic Radiology:* $185K over budget for clinical engineering repairs
- *Special Procedures:* $189K over budget for Patient Chargeable Supplies despite volume decrease
- *Chase Clinic:* $211K unbudgeted line item result of expense sharing with AMG
- *Interest Expense:* $376K over budget on Accretion Expense due to previously unidentified asbestos

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Significant Year End Adjustments

Waterbury Hospital experienced a slight gain from operations through June 2010. However, the final three months of the year resulted in an approximate $5.7 million loss from operations, resulting in a year-end loss from operations of $5.5 million.

The following represents significant adjustments to the final three months of FY2010:

- $5.9 million decrease in the average net revenue when compared to the previous nine months:
  - Favorable FY 2010 Medicaid cost report settlement of $1.8 million
  - Net revenue decrease of approximately $6.1 million primarily a result of decline in volume
  - Fair Pay Workers' Compensation adjustment of receivables to 45% collectability, with an unfavorable impact of $1.8 million
  - Medicaid outpatient audit unfavorable impact of $1.1 million (management estimate)
  - Bad debt / free care / UCP decrease of $1.3 million

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Significant Year End Adjustments (continued)

The following represents significant adjustments to the final three months of FY2010 (continued):

- $295 thousand increase in average expenses when compared to the previous nine months:
  - Workers' Compensation actuarial favorable adjustment of $700 thousand to expense
  - Operations improvement expense decrease of approximately $870 thousand
  - Medical and surgical supplies expense decrease of approximately $855 thousand
  - $380K over budget on Accretion Expense due to previously unidentified asbestos
  - Purchased services expense increase of approximately $1.4 million
  - Alliance Medical Group expense increase of approximately $870 thousand
  - Other expense increases of approximately $70 thousand
- $470 thousand increase in average other operating revenue when compared to the previous nine months

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Section 3
FY 2011 Budget

PRICEWATERHOUSECOOPERS

Significant Budget Assumptions

- Refinancing – generates approximately $13.4 million in cash
- Volume assumptions:
  - Discharges increased from 13,046 (FY 2010 Actual) to 13,100 for FY 2011 budget
  - Average Length of Stay held constant at FY 2010 actual of 4.5 days
  - Outpatient cases decreased from 168,418 to 167,936, a decrease of 0.29%
- No change to Medicare case mix from FY 2010 Actual (through June)
- Medical/Surgical supply expense savings initiative related to utilization and state contracts ($2,095,000 in savings)
- Payer mix assumes no changes in FY 2011 from FY 2010 actual
- Cerner 10% contingency fee worth approximately $511K not reflected in FY2011 budgeted capital uses

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Volume Roll Forward

	Budget 2011	Comments
Projected 2010 I/P Cases	**13,007**	**Based on 10/09-8/10 Actual (11,936) plus 9/10 Projected (1,071)**
Adjustments:		
Angioplasty	11	Annualized YTD June 2010
Gynecology-Surgical	13	Increased to FY09 levels
Major Joint	5	Annualized YTD June 2010
Maternity	-	Annualized YTD Feb 2010 plus 14 Charter Oak cases
Medical	136	Annualized YTD Feb 2010 plus 50 cases (per Kelvin) & 200 Observation cases
Medical Cardiology	(30)	Annualized YTD Feb 2010
Mental Disease / Substance Abuse	(7)	Annualized YTD Feb 2010 plus 9%
Neurosurgery	(12)	Annualized YTD Feb 2010 less 17 cases (per EMT)
Newborn	(3)	Annualized YTD Feb 2010 less 2% plus 14 Charter Oak cases
Ortho	(41)	Annualized YTD Feb 2010
Ortho - Nonsurgical	(7)	Annualized YTD Feb 2010
Surgical	4	240 per quarter (per EMT), plus 10 new cases (per Kelvin)
Surgical Cardiology	37	Annualized YTD Feb 2010, plus 10 new open heart plus 21 new pacemakers
Urology	(13)	Annualized YTD Feb 2010, decreased as a result of DaVinci robot at St. Mary's
Total Adjustments	**93**	
Total Cases - Budget 2011	**13,100**	

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Summary of Potential Adjustments

Net Revenue	Proposed Adjustment to Budget	Potential Volume Exposure	Total
Medicare Case Mix Index			
Acute Renal Failure Coding Change	$ (1,403,000)		$ (1,403,000)
FY 2010 Case Mix - (1.715 to 1.6956)	(723,000)		(723,000)
Decline in Surgical Cases*		$ (5,624,000)	(5,624,000)
Observation Cases (Medicare)	(595,000)		(595,000)
Fair Pay - Overstatement of Charges	295,000		295,000
Fair Pay - Adjustment to Current Payment Rates from Potential Contract Rates	(350,000)		(350,000)
Outpatient Payment Factors	(1,520,000)		(1,520,000)
Medicaid Outpatient Audit Exposure	(733,000)		(733,000)
RAC Audit Exposure (FY 2011)	(1,040,000)		(1,040,000)
Medicare Physician Payment Reduction (23% Jan - Sept)[1]	(125,000)		(125,000)
Commercial Insurance Adjustment (No Support)	255,000		255,000
Medicare Inpatient Prospective Payment System Final Rule	(273,000)		(273,000)
Length of Stay and Payor Mix	(700,000)		(700,000)
TOTAL Net Revenue Adjustment	**$ (6,912,000)**	**$ (5,624,000)**	**$ (12,536,000)**

** Estimated to be a decline of 360 orthopedic discharges based upon the latest volume trends. This translates to a potential exposure of approximately $5,624,000 (360 cases x net revenue of $15,622 per orthopedic surgical case) assuming this trend continues.*

[1] Reduced reimbursement unlikely to occur.

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Summary of Potential Adjustments (continued)

- **Acute Renal Failure Coding Change**
  - Regulatory change (statutory on 10/1/10) where acute renal failure is no longer a Major Complication and Comorbidity (MCC) and is now a Complication and Comorbidity (CC). Hospital had 343 Medicare cases where acute renal failure was the only MCC. We adjusted to the CC payment factor for 75% of the cases
- **FY 2010 Case Mix**
  - Reduction in case mix from budgeted 1.715 to actual FY 2010 of 1.6956
- **Decline in Surgical Cases**
  - Exposure due to orthopedic surgeons moving surgical volume to other hospitals and decline in surgical volume in second half of FY 2010 and decline in October 2010
- **Observation Cases (Medicare)**
  - Reduction in case mix from overall Medicare (budget FY 2011) 1.715 to .7908 (actual Medicare case mix for observation cases) for 85 Medicare observation cases that management has assumed will convert to inpatient
- **Fair Pay – Overstatement of Charges**
  - Budget assumed $2.5 million in Fair Pay charges. Actual FY 2010 charges were approximately $1.5 million. Therefore, Fair Pay impact was overstated in FY 2011 budget
- **Fair Pay – Adjustment to Current Payment Rates from Potential Contract Rates**
  - Reduction in Fair Pay payment factor from 47% to 25%. Budget assumes Fair Pay contract (that is assumed to pay 45% of charges) will be entered into for FY 2011. Through November 2010, no contract signed and no contract discussions occurring

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Summary of Potential Adjustments (continued)

- **Outpatient Payment Factors**
  - Six percent charge increase not factored into Payment on Account Factor (PAF), thus overstating net revenue. Overstatement minimized by a 4% update factor used rather than the managed care and commercial update factor of 9% and 6%
- **Medicaid Outpatient Audit (FY 2011)**
  - Calculated as management's reserve estimate of $1.1 million for the 18 months ending 9/30/09. Applied to FY 2011. External auditors indicated there is enough general reserve at 9/30/10 to cover FY 2010 exposure
- **RAC Audit Exposure (FY 2011)**
  - Management indicated there was $40,000 and $240,000 of exposure for the first two record reviews by RAC. Record requests for review can be made every 45 days. Exposure calculated at average exposure to-date ($140,000) applied to eight potential reviews per year for FY 2011
- **Medicare Physician Payment Reduction (23%)**
  - Total budgeted Medicare physician payments of approximately $725,000 were reduced by 23% for nine months of FY 2011 (Congress passed one-month fix to the Medicare payment formula, not likely to occur)
- **Commercial Insurance Adjustment (No Support)**
  - Exposure due to lack of support for inpatient commercial insurance rate decrease

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Summary of Potential Adjustments (continued)

- **Medicare Inpatient Prospective Payment System Final Rule**
  - Represents using the final Medicare Inpatient Prospective Payment rate for FY 2011 vs. the proposed rule for the budget
- **Length of Stay and Payor Mix**
  - Utilized the final, actual FY 2010 length of stay and payor mix for net revenue calculations

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Review of 2011 Monthly Budget Spread Observations

- Total budgeted admissions spread to each month based on non-holiday / non-weekend days per month, as adjusted for the following:
  - Management's estimate of seasonality
  - Additional 200 observation admissions, the impact of which will not begin to be realized until January 2011
  - Approximately 160 discharges were moved out of first quarter of budgeted FY 2011 to the last nine months of FY 2011 to account for seasonality and ramp up of additional observation admissions
- The following were the monthly expense allocation methodologies employed by Management for each expense category:
  - Gross charges / contractual allowances / bad debt / free care / UCP: based on allocated admissions (see above)
  - OOR / NOR: allocated evenly to each month
  - Salary: based on total days in each month
  - Benefits: based on pay dates in each month
  - Professional legal: allocated evenly to each month

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Cerner Implementation Capital Expenses

- Projected Cerner and IT capital expenses for FY2010 – FY2016 total over $19M
- Cerner incremental operating expense for FY2011 budgeted at $2.3M
- Cerner project cost for FTEs is estimated at an ongoing impact of $525,232, which is not reflected in the Cerner budgeted operating expenses

	FY10	FY11	FY12	FY13	FY14	FY15	FY16	TOTAL
Cerner Contract-Related Capital Costs								
License Software		$ 330,286	$ 90,194	$ 90,194	$ 90,194	$ 90,194	$ 90,194	$ 781,258
Implementation / Services		520,364	323,500	548,417	323,500	520,364	302,453	2,538,598
Hardware Costs	$ 423,489	300,000	160,894					884,383
Total Cerner Only Capital Costs & Hardware	**423,489**	**1,150,650**	**574,588**	**638,611**	**413,694**	**610,558**	**392,647**	**4,204,239**
Non-Cerner Fees - Capital								
Consulting Fees	1,000,000	2,000,000	1,000,000					4,000,000
Internal Capital Budgeted Updgrades	986,000	1,500,000	1,500,000	1,572,000	1,217,000	1,085,000	1,070,000	8,930,000
Cerner Travel to WH	31,350	198,725	90,000					320,075
3rd Party Travel to WH	48,000	264,000	288,000					600,000
Total Costs (Capital)	**2,488,839**	**5,113,375**	**3,452,588**	**2,210,611**	**1,630,694**	**1,695,558**	**1,462,647**	**18,054,314**
Contingency - 10%	**248,884**	**511,338**	**345,259**					**1,105,480**
Out of Scope Total (Contingency Used)	**25,000**	-	-	-	-	-	-	**25,000**
Annual Totals	**$ 2,762,723**	**$ 5,624,713**	**$ 3,797,847**	**$ 2,210,611**	**$ 1,630,694**	**$ 1,695,558**	**$ 1,462,647**	**$ 19,184,794**

* Provided by Waterbury Hospital

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Budget Recommendations

- Implement an integrated budgeting system and process
  - Existing database is homegrown
  - Current process is heavily reliant on Excel spreadsheets
  - Standardize annual and monthly budget “packages”
- Adopt consistent budget methodology
  - Modeling should segregate inputs, calculations, and review sheets
  - Improve work paper documentation
  - Presentation of significant detailed assumptions should be improved
  - Gross and net revenue assumptions not well documented
- Coordination of budget process needs to be improved
- Adopt consistent budget review process
- Create and document policies and procedures
- Consider documenting exposure items and threats

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Budget Recommendations (continued)

- Improve discipline around budget to actual process to ensure alignment of budget and actual line items expenses by cost center to improve transparency of budgeting discrepancies
- Set consistent expectations for accountability and monthly feedback on any budget to actual variances by cost center
- Improve controls around revenue and expense sharing with Alliance Medical Group
- Clinical engineering repair budget needs to take into consideration increasing age of plant and equipment
- Reinstate position control process
- Each department should budget replacement time with applicable overtime and temporary help allocations
- Realign staffing to reflect the 0.5 day drop in LOS achieved through patient throughput initiatives

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Budget Recommendations (continued)

- Recommendations for monthly budget allocations:
  - To begin, the monthly spread of the FY 2011 budget is an improvement over the prior year, where everything was allocated evenly to each month, as adjusted for monthly initiatives
  - Going forward, best practice is to incorporate actual historical volume and expense trends into the monthly revenue and expense allocations (where appropriate)
  - Interest expense should be allocated to each month based on actual amortization schedules
  - Depreciation expense allocations should incorporate when assets are anticipated to come on-line during the year
  - Work paper documentation of the monthly budget spread process, including all assumptions, should be improved

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Section 4
Hospital Run Rate

PRICEWATERHOUSECOOPERS

Meeting with External Auditors

We met with Chris Jackson, Partner, Marcum, LLP, on November 23. The following is a summary of our discussion:

- The audit is progressing and the auditors are planning on field work to be completed week of November 29
- The Hospital is in the process of updating the financial statements for all known adjustments
- All known audit adjustments are recorded by the Hospital for FYs 2008 through 2010. The look-back procedures for accounts receivable have not resulted in any significant adjustments
- General reserves appear to be adequate to cover all know exposures through September 30, 2010 and include the following:
  - Recover Auditor Contractor (RAC)
  - Outpatient Medicaid
  - Fair Pay Workers Compensation accounts receivable valuation (assume collection at 45% of charges – see following slides)

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Fair Pay Workers Compensation

- Management has represented that they will collect up to 45% of gross charges for Fair Pay Workers Compensation accounts receivable:
  - Total Fair Pay accounts receivable has a balance of $2,861,000 on accounts for the period FY 2006 through FY 2010
  - Total reserves for the Fair Pay accounts receivable is approximately $1,854,000, leaving a net value of $1,007,000 at September 30, 2010
  - Hospital has currently been paid $1,330,000 on these accounts which represents a collection percentage of 25.6%
  - Hospital has hired an outside agency and an outside attorney to assist with obtaining a contract going forward and a settlement of prior open accounts receivable balances

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Fair Pay Workers Compensation (continued)

- The following summarizes the potential exposure to Waterbury Hospital if no further monies are received related to Fair Pay Workers Compensation claims for FY2006-FY2010:

A	*B*	*C*	*D*	*E*	*F*
					EXPOSURE
Fiscal Year	Gross Revenue	Management-Assumed Net Revenue at 45% of Charges *(B x 45%)*	Collections To-Date	Collection % To-Date *(D ÷ B)*	Management-Assumed Left to Collect at 45% *(C - D)*
FY2006	$ 166,747	$ 75,036	$ 40,940	24.55%	$ 34,096
FY2007	952,771	428,747	250,844	26.33%	177,903
FY2008	1,301,048	585,472	355,565	27.33%	229,907
FY2009	1,324,549	596,047	333,898	25.21%	262,149
FY2010	1,447,547	651,396	348,890	24.10%	302,506
Total	**$ 5,192,662**	**$ 2,336,698**	**$ 1,330,137**	**25.62%**	**$ 1,006,561**

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Adjustments That Are Related to Prior Years

	Prior Years	2008	2009	2010
(Loss) From Operations per Audited Financial Statements		$ (12,360,105)	$ (4,986,257)	$ (7,756,250)
Fiscal Year 2010 Third Party Reserve Adjustments, Settlements, and Appeals	$ 837,221	86,865	(281,020)	(643,066)
Fiscal Year 2010 Adjustments to Expenses	0	0	0	0
	837,221	86,865	(281,020)	(643,066)
Fiscal Year 2009 Third Party Reserve Adjustments, Settlements, and Appeals	534,614	526,300	(1,060,914)	0
Fiscal Year 2009 Adjustments to Expenses	0	0	0	0
	534,614	526,300	(1,060,914)	0
Fiscal Year 2008 Third Party Reserve Adjustments, Settlements, and Appeals	1,932,004	(1,932,004)	0	0
Fiscal Year 2008 Adjustments to Expenses	0	0	0	0
	1,932,004	(1,932,004)	0	0
Total FY 2010, 2009, 2008 Adjustments	**3,303,839**	**(1,318,839)**	**(1,341,934)**	**(643,066)**
Adjusted (Loss) From Operations	**$ 3,303,839**	**$ (13,678,944)**	**$ (6,328,191)**	**$ (8,399,316)**
Medicare Section 508 Wage Index Incremental Net Revenue		**$ 697,000**	**$ 1,477,000**	**$ 1,358,000**

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Prior Year Adjustments - Detail

Adjustment Number	Adjustment Description	Actual			
		Prior Years	2008	2009	2010
	(Loss) From Operations per Audited Financial Statements		$ (12,360,105)	$ (4,986,257)	$ (7,756,250)
	Fiscal Year 2010 Adjustments				
1	FY 2003 Medicare Bad Debt and DSH Reopening	$ 617,221			(617,221)
2	FY 2004-2006 Medicare Bad Debt Reopening	220,000			(220,000)
3	FY 2008 Medicare Audit Adjustments		453,532		(453,532)
4	FY 2009 As Filed Medicare Cost Report			452,313	(452,313)
5	FY 2010 Medicaid Cost Report				TBD
6	Fair Pay Adjustments to Accounts Receivable				TBD
7	Medicaid Outpatient Audit Additions		(366,667)	(733,333)	1,100,000
	Fiscal Year 2010 Adjustment Subtotal	837,221	86,865	(281,020)	(643,066)
	Fiscal Year 2009 Adjustments				
1	FY 1997 Medicare DSH Appeal	720,222		(720,222)	
2	FY 2000 Medicare DSH Appeal	80,250		(80,250)	
3	FY 2001 Medicare DSH Appeal	234,595		(234,595)	
4	FY 2002 Medicare DSH Appeal	131,780		(131,780)	
5	FY 2002 Reopening Cross Over Bad Debts	40,027		(40,027)	
6	FY 2007 Medicare Audit Adjustments Summary Exit Conference	(171,185)		171,185	
7	FY 2007 MedicareTricare/Champus 2007 Initial Cost Report Settlement	19,872		(19,872)	
8	FY 2008 Medicare Miscellaneous		5,441	(5,441)	
9	FY 2007 Medicaid Cost Report	(538,558)		538,558	
10	FY 2007 Medicaid Cost Report	17,611		(17,611)	
11	FY 2008 Medicaid Outpatient Audit		520,859	(520,859)	
	Fiscal Year 2009 Adjustment Subtotal	534,614	526,300	(1,060,914)	
	Fiscal Year 2008 Adjustments				
1	FY 1992-1994 Appeal-Baystate	(84,440)	84,440		
2	Reopening Settlement Net of DSH	460,984	(460,984)		
3	FY 2005 Medicare As Filed Cost Report	(231,659)	231,659		
4	FY 2005 Medicare Initial Settlement	73,000	(73,000)		
5	FY 2005 Medicare Revised After FY 2004 audit and 2005 overlap	149,117	(149,117)		
6	FY 2005 Medicare Final Settlement	279,584	(279,584)		
7	FY 2006 Medicare Revised after FY 2004 Audit	141,934	(141,934)		
8	FY 2007 Medicare Initial Settlement	444,640	(444,640)		
9	FY 2005 Medicaid Outpatient Audit	110,077	(110,077)		
10	FY 2005 Medicaid As-filed Cost Report	(324,183)	324,183		
11	FY 2006 Medicaid As-filed Cost Report	37,081	(37,081)		
12	FY 2006 Medicaid Outpatient Audit	23,073	(23,073)		
13	FY 2007 Medicaid Misc.	9,238	(9,238)		
14	FY 2007 Medicaid Cost Report Not Yet Filed	538,558	(538,558)		
15	FY 2008 Reserve Adjustment	305,000	(305,000)		
	Fiscal Year 2008 Adjustment Subtotal	1,932,004	(1,932,004)		
	Total FY 2010, 2009, 2008 Adjustments	**3,303,839**	**(1,318,839)**	**(1,341,934)**	**(643,066)**
	Adjusted (Loss) From Operations	**$ 3,303,839**	**$ (13,678,944)**	**$ (6,328,191)**	**$ (8,399,316)**

*Per Consolidating Statement of Operations
Waterbury Hospital Only

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Section 5
Decision Support and Marginal Profitability

PRICEWATERHOUSECOOPERS

Decision Support Observations

- Trendstar Decision Support system has been in place since 1993
  - DOS-based
  - System performance issues
- All costs spread using ratio of cost to charges
- Difference between internal financial statement net revenue and net revenue per Trendstar is spread based on percent of total gross charges
  - No time and motion studies used
  - No RVUs used
- Decision support output is directional. More in-depth analysis needs to be performed before action is taken

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Product Line Recommendations

- **General**
  - Indirect fixed costs in FY 2010 are 38%of total costs. Reducing this percentage to a benchmark of 35% would save approximately $6.9 million
  - Each product line should have a detailed business plan that considers volume trends, reimbursement, and steps to improve operational efficiencies
  - Document key inputs and assumptions to the models for consistency on a roll forward basis
- **Psychology**
  - Approximately 42% of psychology volume is driven by Medicaid
  - Certificate of Need approval is required by the Office of Health Care Access in order to discontinue psychology services
  - Business plan should include lobbying for increased Medicaid rates
  - All grant funded programs should fully cover the salary and expenses, with evaluation of this each year to determine continuation
- **Cardiology**
  - The CVU transitional care model is a more expensive model of care
  - National trends show a decrease in open heart surgeries
  - The CAW physician alignment strategy should improve volume

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Product Line Recommendations

- **Observation**
  - Increase in observation days/admissions corresponds to better patient identification by case management
  - Management has recently contracted with Accretive Health to address documentation gaps with observation status patients and those who convert to inpatient
  - Observation units rarely stand on their own bottom financially – rather they provide open bed capacity for higher contribution inpatient cases
- **Offsite Outpatient Services**
  - Determine business plan for offsite services including volume requirements to continue business
  - Evaluate frequency of services and actual modalities available. Interview physician users of offsite locations to understand their practice and referral patterns

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Fiscal Year 2010 Profitability by Product Line - Direct Margin*

Fiscal Year 2010 Profitability by Product Line* (in thousands)

	Needs Improvement → Performing														
	EEG	GI	Psych	Observation	Sleep Lab	Outpatient Labs	Offsite Outpatient Services	Women & Infants	Radiology	ER	Cardiology	Orthopedics	All Other Surgery	IP - Medical	Total
Gross Charges	$ 1,828	$ 5,142	$ 53,751	$ 20,360	$ 9,196	$ 22,717	$ 28,260	$ 33,102	$ 28,876	$ 83,215	$ 116,904	$ 91,614	$ 164,121	$ 158,240	$ 817,326
Contractual Allowances (Inferred)	(1,285)	(3,316)	(40,078)	(16,353)	(6,950)	(18,364)	(21,646)	(21,335)	(23,173)	(63,059)	(87,133)	(61,969)	(119,811)	(109,567)	(594,039)
Net Revenue	543	1,826	13,673	4,007	2,246	4,353	6,614	11,767	5,703	20,156	29,771	29,645	44,310	48,673	223,287
Direct Department Cost	(215)	(1,109)	(10,370)	(2,793)	(1,004)	(2,830)	(4,444)	(8,382)	(2,071)	(9,523)	(18,000)	(17,678)	(22,129)	(22,800)	(123,348)
Direct Department Beneifts	(11)	(201)	(2,697)	(474)	(155)	(361)	(482)	(1,476)	(269)	(1,888)	(2,340)	(1,368)	(3,218)	(4,504)	(19,444)
Direct Contribution Margin	$ 317	$ 516	$ 606	$ 740	$ 1,087	$ 1,162	$ 1,688	$ 1,909	$ 3,363	$ 8,745	$ 9,431	$ 10,599	$ 18,963	$ 21,369	$ 80,495
Direct Contribution Margin % of Net Revenue	58%	28%	4%	18%	48%	27%	26%	16%	59%	43%	32%	36%	43%	44%	36%
Typical Capital Intensity	Low	Medium	Low	Low	Low	Low	Low	Low	High	Medium	High	High	High	Low	
Waterbury Hospital-specific Capital Intensity	Low	High	Low	Medium	Low	Low	Low	Low	Medium	High	High	High	High	High	

* Data provided by Waterbury Hospital

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Fiscal Year 2010 Profitability by Product Line – Net Margin*

Fiscal Year 2010 Profitability by Product Line (in thousands)

	Needs Improvement → Performing														
	Psych	Women & Infants	Cardiology	Observation	Offsite Outpatient Services	Outpatient Labs	GI	Orthopedics	EEG	Sleep Lab	Radiology	All Other Surgery	ER	IP - Medical	Total
Gross Charges	$ 53,751	$ 33,102	$ 116,904	$ 20,360	$ 28,260	$ 22,717	$ 5,142	$ 91,614	$ 1,828	$ 9,196	$ 28,876	$ 164,121	$ 83,215	$ 158,240	$ 817,326
Contractual Allowances (Inferred)	(40,078)	(21,335)	(87,133)	(16,353)	(21,646)	(18,364)	(3,316)	(61,969)	(1,285)	(6,950)	(23,173)	(119,811)	(63,059)	(109,567)	(594,039)
Net Revenue	13,673	11,767	29,771	4,007	6,614	4,353	1,826	29,645	543	2,246	5,703	44,310	20,156	48,673	223,287
Direct Department Cost	(10,370)	(8,382)	(18,000)	(2,793)	(4,444)	(2,830)	(1,109)	(17,678)	(215)	(1,004)	(2,071)	(22,129)	(9,523)	(22,800)	(123,348)
Direct Department Beneifts	(2,697)	(1,476)	(2,340)	(474)	(482)	(361)	(201)	(1,368)	(11)	(155)	(269)	(3,218)	(1,888)	(4,504)	(19,444)
Direct Contribution Margin	606	1,909	9,431	740	1,688	1,162	516	10,599	317	1,087	3,363	18,963	8,745	21,369	80,495
Indirect Fixed Cost	(6,724)	(5,918)	(12,126)	(2,055)	(2,606)	(1,905)	(974)	(10,567)	(138)	(645)	(1,626)	(17,167)	(6,753)	(17,624)	(86,828)
Net Margin	$ (6,118)	$ (4,009)	$ (2,695)	$ (1,315)	$ (918)	$ (743)	$ (458)	$ 32	$ 179	$ 442	$ 1,737	$ 1,796	$ 1,992	$ 3,745	$ (6,333)
Net Margin % of Net Revenue	-45%	-34%	-9%	-33%	-14%	-17%	-25%	0%	33%	20%	30%	4%	10%	8%	-72%

* Data provided by Waterbury Hospital

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FY 2010 Discharge Profitability by Payer (Per Discharge)

FY 2010 Inpatient (Per Discharge)	Self Pay	Medicaid	Managed Medicaid	Managed Medicare	Medicare	Managed Care	Commercial	Workers Comp	TOTAL
Gross Charges	$ 32,426	$ 35,668	$ 16,748	$ 50,214	$ 47,408	$ 37,022	$ 37,290	$ 56,594	$ 39,670
Contractual Allowances (Inferred)	(30,462)	(29,495)	(13,030)	(36,599)	(33,813)	(25,064)	(21,667)	(18,628)	(28,217)
Net Revenue	1,964	6,173	3,718	13,616	13,595	11,957	15,624	37,966	11,453
Direct Department Cost	(4,589)	(5,343)	(3,675)	(8,008)	(7,392)	(6,447)	(6,279)	(10,281)	(6,468)
Direct Department Benefits	(767)	(992)	(673)	(1,158)	(1,153)	(807)	(866)	(880)	(980)
Direct Contribution Margin	(3,392)	(163)	(630)	4,449	5,049	4,703	8,479	26,806	4,005
Indirect Fixed Cost	(3,319)	(3,889)	(2,549)	(5,594)	(5,254)	(4,256)	(4,276)	(6,379)	(4,509)
Net Margin	$ (6,711)	$ (4,052)	$ (3,179)	$ (1,145)	$ (205)	$ 448	$ 4,203	$ 20,428	$ (504)

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FY 2010 Discharge Profitability by Payer (Total Discharges)

FY 2010 Inpatient (Total)	Self Pay	Medicaid	Managed Medicaid	Managed Medicare	Medicare	Managed Care	Commercial	Workers Comp	TOTAL
Gross Charges	$ 5,544,821	$ 55,391,961	$ 24,904,401	$ 43,184,222	$ 247,517,363	$ 94,331,254	$ 41,765,178	$ 4,980,273	$ 517,619,473
Contractual Allowances (Inferred)	(5,208,930)	(45,805,737)	(19,376,153)	(31,474,805)	(176,539,437)	(63,863,985)	(24,266,635)	(1,639,223)	(368,174,905)
Net Revenue	335,891	9,586,224	5,528,248	11,709,417	70,977,926	30,467,269	17,498,543	3,341,050	149,444,568
Direct Department Cost	(784,757)	(8,298,175)	(5,464,970)	(6,887,025)	(38,594,942)	(16,428,112)	(7,031,942)	(904,721)	(84,394,644)
Direct Department Benefits	(131,110)	(1,540,869)	(1,000,630)	(996,087)	(6,019,739)	(2,054,982)	(969,576)	(77,397)	(12,790,390)
Direct Contribution Margin	(579,976)	(252,820)	(937,352)	3,826,305	26,363,245	11,984,175	9,497,025	2,358,932	52,259,534
Indirect Fixed Cost	(567,593)	(6,039,976)	(3,789,925)	(4,810,651)	(27,431,102)	(10,843,401)	(4,789,552)	(561,312)	(58,833,512)
Net Margin	$ (1,147,569)	$ (6,292,796)	$ (4,727,277)	$ (984,346)	$ (1,067,857)	$ 1,140,774	$ 4,707,473	$ 1,797,620	$ (6,573,978)

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Section 6
Initiatives Dashboard

PRICEWATERHOUSECOOPERS

Initiative Dashboards

Current initiative dashboards were reviewed and resulted in the following findings:

- All initiative dashboards are prepared by Executive Director of Process Improvement, Randy Essenberg, and populated on the internal website for board and management review
- A total of approximately 45 initiative dashboards are managed and available for reference (see following slide)
- It is reported that initiative dashboards are not consistently reviewed and prioritized by board members
- It is reported that management does not regularly respond to issues presented in the initiative dashboards
- Sample trending based on the target and actual metrics outlined in the dashboards for nursing and linen utilization initiatives are provided on the following slides

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Initiative Dashboards

Below is a list of the available initiative dashboards:

- Outpatient Testing
- Sleep Lab
- Cardiology
- EEG
- GI
- Outpatient Medical Therapies
- Floats
- Nursing Unit Summary
- Ortho Unit
- Surgical Unit
- Telemetry
- Medical Unit P5
- CVU
- Critical Care
- Post Anesthesia Care Unit
- Central Sterile Processing
- Operating Room
- Labor Prod./Var. Lbr Optimize
- Linen Utilization
- Materials Management
- Non-Salary Initiatives
- OP BEH
- Overtime Utilization
- Patient Throughput
- Pharmacy
- Plant
- Public Relations/Community Health Education
- Radiology/Imaging Services
- Revenue Cycle
- Safety/Security
- Top 20 DRGs LOS
- Acute Care Behavioral Health
- Bed Control
- Board Quality and Safety Committee
- Cerner Implementation
- Adol and Child
- Clinical Engineering
- Crisis
- Dietary
- Emergency Department Throughput
- FBC and SCN
- Finance
- Infection Prevention Program
- Information Technology
- Laboratory

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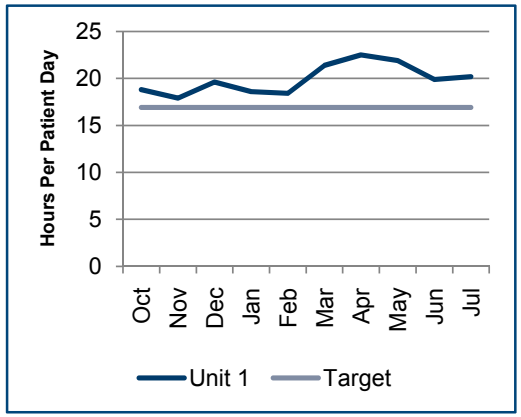
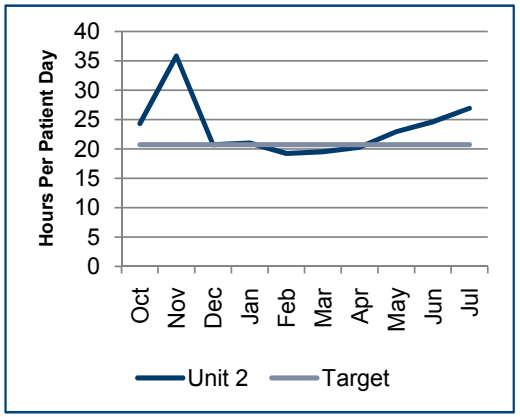
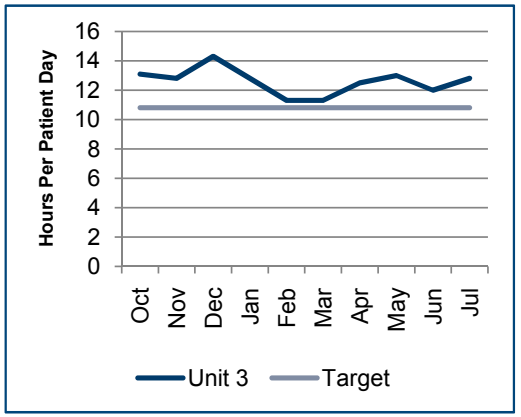
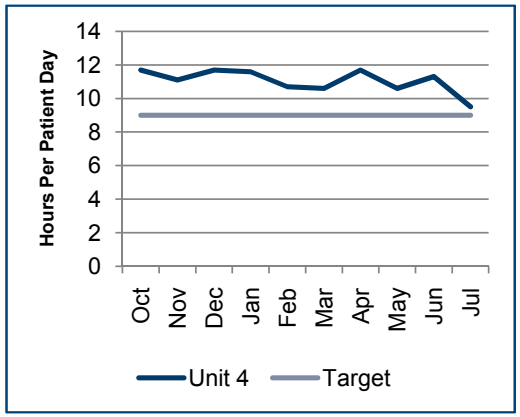
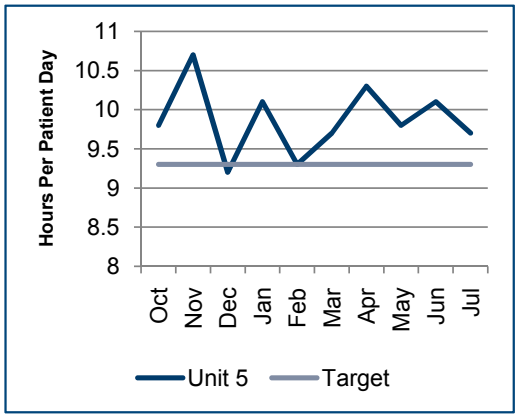
Initiatives - Labor Productivity: Nursing

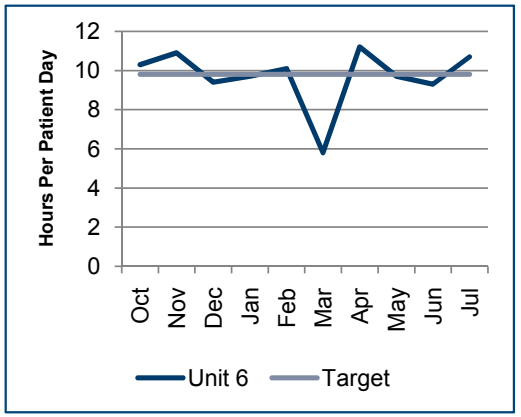












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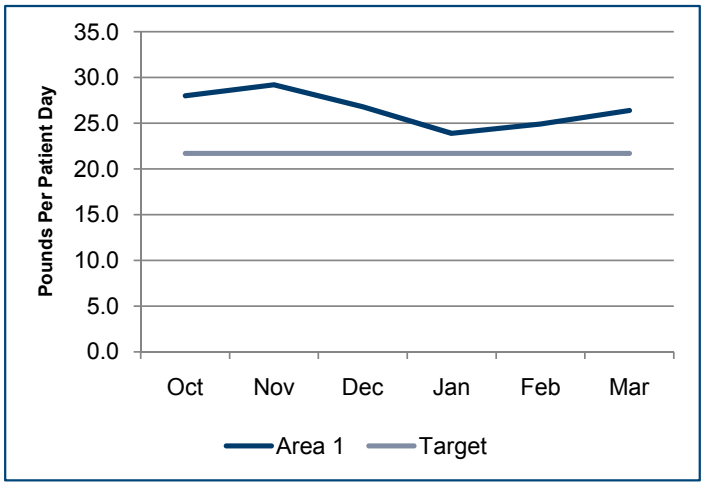
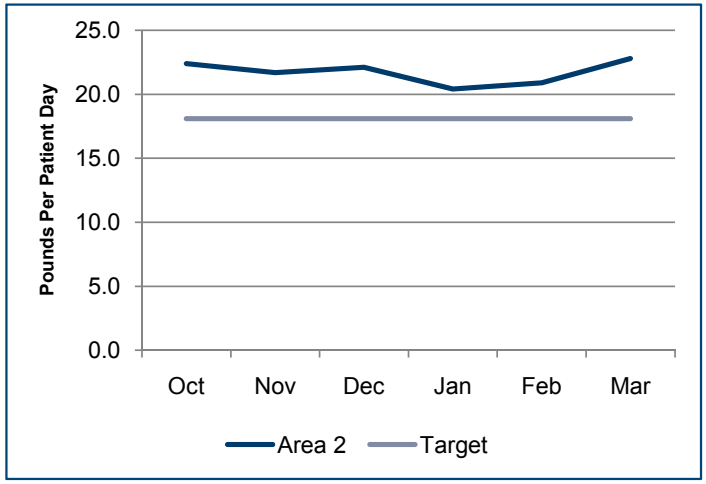
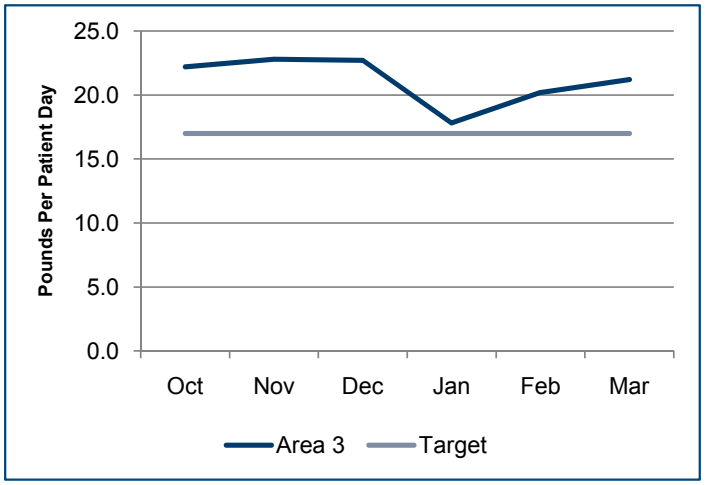
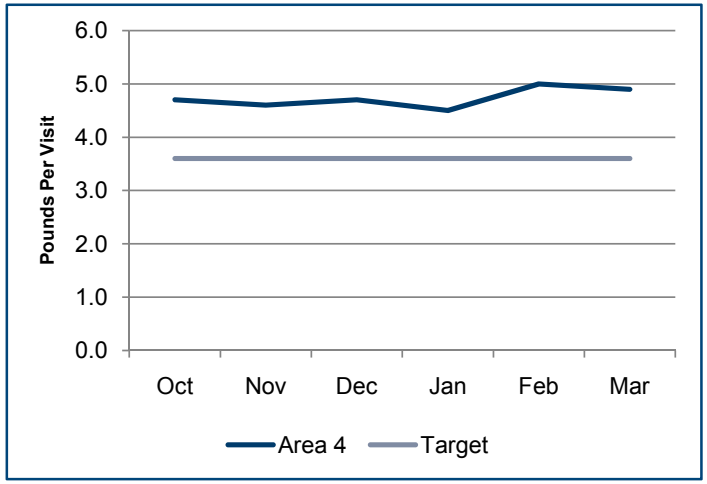
Initiatives – Linen Utilization









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Section 7
Leading Indicators

PRICEWATERHOUSECOOPERS

Recommendations – Monthly Financial Statements Package

Leading Indicators:

- Operating Statistics

	Current Month				Year-to-Date			
	Actual	Budget	Variance	Prior Year	Actual	Budget	Variance	Prior Year
Inpatient Statistics								
Discharges								
Patient Days								
ALOS								
Occupancy Percentage (Staffed Beds)								
Case Mix Index:								
Medicare								
Total								
Surgical Statistics								
Inpatient Surgery								
Outpatient Surgery								
Outpatient / ER Statistics								
Outpatient Cases								
ED Visits:								
Discharged								
Admitted								
Observation Cases								
Cash Collected								
Total Cash Collected								
Payor Mix % (Based on Gross Revenue)								
Medicare								
Managed Medicare								
Medicaid								
Managed Medicaid								
Commercial								
Managed Care								
Self Pay								
Total								

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Recommendations – Monthly Financial Statements Package (continued)

Leading Indicators (continued):

- Financial Ratios and Labor Statistics

Key Financial Ratios	Year-to-Date				Comparator Group			
	Actual	Budget	Variance	Prior Year	Peer Group	S&P BBB	Fitch BBB	Moody's Baa2
Operating Performance								
Operating Margin								
Excess Margin								
Bad Debt as a % of Gross Revenue								
Liquidity								
Days Cash on Hand								
Days in Net Accounts Receivable								
Days in Accounts Payable								
Leverage								
Long-Term Debt to Equity								
Long-Term Debt to Capitalization								
Annual Cash Flow to Total Liabilities								
Unrestricted Cash to Debt								
Maximum Debt Service Coverage								
Average Age of Plant								

Labor and Productivity Statistics	Current Month				Year-to-Date			
	Actual	Budget	Variance	Prior Year	Actual	Budget	Variance	Prior Year
FTEs:								
Routine								
Ancillary								
Support								
Total FTEs								
FTEs per Adjusted Occupied Bed								
FTEs per Equivalent Discharge								

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Recommendations – Monthly Financial Statements Package (continued)

Leading Indicators (continued):

- Statement of Operations and Balance Sheet

Statement of Operations	Current Month				Year-to-Date			
	Actual	Budget	Variance	Prior Year	Actual	Budget	Variance	Prior Year
Revenue								
Gross Revenue								
Contractual Allowances								
Other Allowances								
Net Revenue								
Other Operating Income								
Total Revenue								
Expenses								
Salaries and Benefits								
Non-Salary Expenses								
Depreciation								
Interest								
Alliance Medical Group								
Operations Improvement								
Total Expenses								
Income/(Loss) from Operations								
Non-Operating Income								
Non-Operating Income								
Change in Unrealized Gains and Losses								
Net Income/(Loss)								

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Recommendations – Monthly Financial Statements Package (continued)

Leading Indicators (continued):

- Statement of Operations and Balance Sheet (continued)

Balance Sheet	Current Month			
	Actual	Budget	Variance	Prior Year
Assets				
Cash & Cash Equivalents				
Net Accounts Receivable				
Due from Affiliates				
Assets Whose Use is Limited				
Other Investments				
Net Property, Plant & Equipment				
Other Assets				
Total Assets				
Liabilities & Net Assets				
Accounts Payable				
Accrued Expenses				
Accrued Pension				
Long-Term Debt				
Due to Third-Party Payors				
Other Liabilities				
Net Assets				
Total Liabilities & Net Assets				

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Recommendations – Monthly Financial Statements Package (continued)

Narrative to Monthly Financial Statements

- Management's observations and evaluation of the monthly and year-to-date results should be included in the monthly financial statement package every month. This narrative should be included as the first section of the monthly financial statement package
- This should include observations around comparisons of current month and year-to-date results to budget and to prior year

Leading Indicators

- Enhance current page one of the monthly financial statement package, entitled 'Executive Summary'
- Add month-to-date results
- Add month-to-date comparisons to budget and prior year
- Add year-to-date comparisons to prior year
- Reformat (see the previous few pages for suggested layout)

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Recommendations – Monthly Financial Statements Package (continued)

Comparative Income Statement

- Add month-to-date results
- Add month-to-date comparisons to budget and prior year
- Reformat ($s / underlines / etc.)

Income Statement

- Add operating margin and excess margin %s by month
- Reformat ($s / underlines / etc.)

Comparative Balance Sheet

- Reformat ($s / underlines / etc.)

Statement of Cash Flows

- Add monthly detail for the current fiscal year (currently includes current month only)
- Reformat ($s / underlines / etc.)

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Recommendations – Monthly Financial Statements Package (continued)

Payroll Hours All Departments

- Reevaluate the purpose and usefulness of this schedule
- See suggested labor statistics in leading indicators presentation

Gross A/R Aging

- Reformat schedule
- The following two pages represent a suggested format for the accounts receivable analysis:

Accounts Receivable Analysis						
	Sep '10 A/R	% of Gross A/R	Oct '10 A/R	% of Gross A/R	Nov '10 A/R	% of Gross A/R
Gross A/R	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Less:						
Contractual Allowances		0.0%		0.0%		0.0%
Reserve for Bad Debt		0.0%		0.0%		0.0%
Reserve for Free Care		0.0%		0.0%		0.0%
Subtotal Reserves		**0.0%**		**0.0%**		**0.0%**
Net A/R per Financials	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**

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Recommendations – Monthly Financial Statements Package (continued)

Gross A/R Aging (continued):

Accounts Receivable Aging Analysis								
9/30/2010								
Financial Class	**In-House**	**0-30**	**31-60**	**61-90**	**91-150**	**151-365**	**1+ Year**	**Total**
Blue Cross	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross HMO								-
Blue Cross PPO								-
Commercial HMO								-
Commercial Insurance								-
Commercial PPO								-
Managed Medicaid								-
Managed Medicare								-
Medicaid								-
Medicare								-
SAGA								-
Self Pay								-
Workers Compensation								-
Total 9/30/2010	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
% of Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total 9/30/2009	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
% of Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Change	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
% Change	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

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Recommendations – Monthly Financial Statements Package (continued)

Key Inpatient Indicators / Key Outpatient Indicators

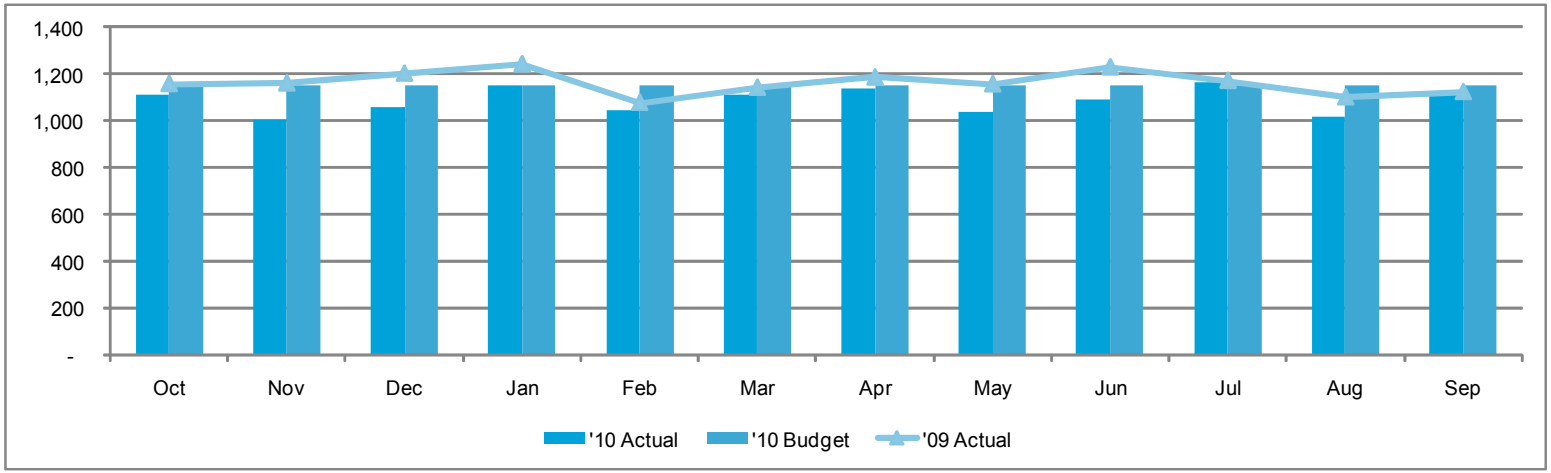
- The following is the suggested change to the current format (develop for Patient Days, ALOS, Outpatient Cases, ED Cases and OR Volume as well):

Admissions

YTD	'10 Actual	'10 Budget	'09 Actual
Total	13,046	13,787	13,928

YTD	'10 Budget	'09 Actual
Variance	(741)	(882)

YTD	'10 Budget	'09 Actual
Percent of	-5.7%	-6.8%



Trend	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
'10 Actual	1,113	1,002	1,060	1,153	1,044	1,113	1,138	1,038	1,093	1,163	1,019	1,110	13,046
'10 Budget	1,148	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	13,787
'09 Actual	1,156	1,159	1,200	1,240	1,076	1,140	1,184	1,155	1,227	1,170	1,099	1,122	13,928

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Recommendations – Monthly Financial Statements Package (continued)

Net Revenue and Expenses per Equivalent Admission Graph

- Reevaluate the purpose and usefulness of this graph
- If the graph is necessary, reformat the layout

Expense Categories as % of Total (Excluding OI and AMG) Graph

- Reevaluate the purpose and usefulness of this graph
- If the graph is necessary, reformat the layout

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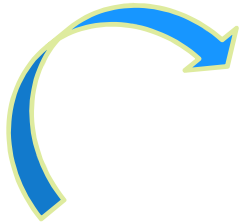
Section 8
Future Considerations

PRICEWATERHOUSECOOPERS

Three Steps of Health Reform



Bending the cost curve (2015-2020)

- Penalty for not adopting electronic medical records
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax
- Medicare Part D "Doughnut Hole" closes
- Reduced payment for hospital-acquired conditions

Major expansion of coverage (2014)

- Mandates for individuals
- Employer penalties for those that do not provide coverage
- Health insurance exchanges
- Small employer and individual subsidies
- Health insurer industry fee
- Guaranteed issue, rating bands, and risk adjustment
- Medicaid expansion
- Disproportionate share payment reductions to hospitals

Regulation and coverage (2010-2013)

- Elimination of pre-existing coverage exclusions for children and lifetime coverage limits and rescissions; dependent coverage through age 26
- MLR minimums for non-grandfathered plans
- Medicare Part D gap narrows, Medicare Advantage rates frozen, bonuses available, beneficiary rebates, free preventive care
- Temporary high risk pools
- Fee on brand -name pharmaceutical manufacturers
- Community Living and Support Services Act (CLASS Act)

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Three Steps of Health Reform

2010
- Physician-owned hospital Medicare provider agreements must be in place
- New exemption requirements for tax-exempt hospitals
- Reduction in annual market basket update to Medicare providers
- Enhanced Medicare and Medicaid provider screenings

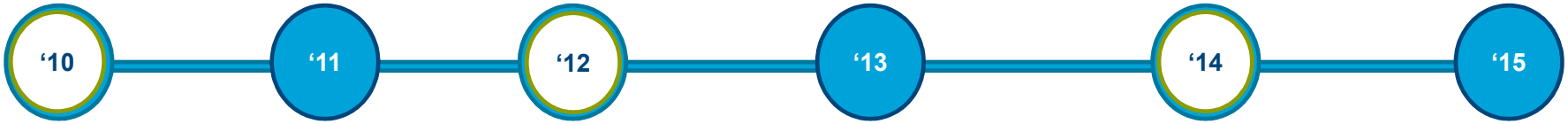
2011
- Grants for medical malpractice reduction demonstration projects
- 10% Medicare bonus for primary care and general surgeons in a health professional shortage area (ends 2015)
- Prohibit federal Medicaid payments for HAC
- Federal funding of Medicaid medical home
- New funding for community health centers, school-based clinics, and trauma center program

2012
- Accountable care organizations (ACOs)
- Medicare payments reductions for preventable readmissions
- Medicare value-based purchasing for hospitals
- Medicaid bundled payment demonstrations

2013
- Medicare bundled payment demonstration
- Increase Medicaid primary care payments
- Financial relationship disclosure requirements
- Value-based payment for physician fee
- Community needs assessment to be completed and implemented

2014
- Expand Medicaid
- Disproportionate Share Hospital (DSH) reductions

2015
- Reduce Medicare payments for hospital-acquired conditions by 1%
- Penalties for providers that have not achieved meaningful use of EHRs (HITECH Act)



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"4 Key Themes" of Healthcare Reform

HOW do you measure up?

- Quality and efficiency will increasingly impact how providers are paid.
- Focus is on all the additional ways providers will be evaluated, compared and reported.
- Clients should know how they will be measured and what they can do to improve the results.

HOW do you thrive on governmental reimbursement?

- More revenue under health reform, but increasingly restrictive government sector payments bring continued challenges to providers.
- An ever increasing percentage of patients paid under governmental rates, over next 10 year >10% increase could be expected.
- Cost containment and efficient delivery of services will be needed for success.

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"4 Key Themes" of Healthcare Reform

HOW do you think outside of this box?

- A provider's ability to manage across the entire continuum of care will increasingly impact its viability.
- PwC's clients (primarily Hospitals and Health Systems) need to consider impact of the legislation on the broader health delivery system.
- Clients should focus on defining and delivering cost effective and high quality care.

HOW do you ensure you are doing the right thing?

- Health reform increases our regulatory environment but also puts heightened focus on community needs and tax-exempt status.
- Expansion in regulatory environment of healthcare and more public disclosure means risks associated with compliance is increasing.
- Compliance should be treated as a fundamental part of doing business not as an independent discrete function.

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Future Considerations

The following are regulatory and health care reform related items that must be considered over the next few years:

- No increases in Government payments
- Payment reductions for quality:
  - Readmissions
  - Hospital acquired conditions (HACs)
  - Value Based Purchasing
- Meaningful use
- ICD-10
- HIPAA 5010
- Community Needs Assessment
- Red Flags
- RACs
- Accountable Care Organizations/Bundled Payments/Capitation

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Impact of Quality Incentives and Paying for Health Reform

What institutions should expect in terms of revenue trends under health reform:

- Medicare – a cumulative 3 to 13% decrease in inpatient payments from 2011 to 2015 and similar trends in outpatient activity; and a cumulative 15 to 26% differential relative to market basket
- Medicaid – currently uninsured will shift into Medicaid creating a boost in Medicaid volume. However, given budget constraints at the state level, can any increases be expected for at least a couple of years?
- Exchanges – currently uninsured will shift into programs through the exchanges, but can it be expected that payment levels will be much greater than Medicare?
- Commercial – no better than inflationary increases. In addition, depending on the nature of employer groups, some level of existing volume under commercial insurance will shift to exchange programs
- Self-pay – the level of uninsured may decrease, however, secondary self pay will continue to escalate

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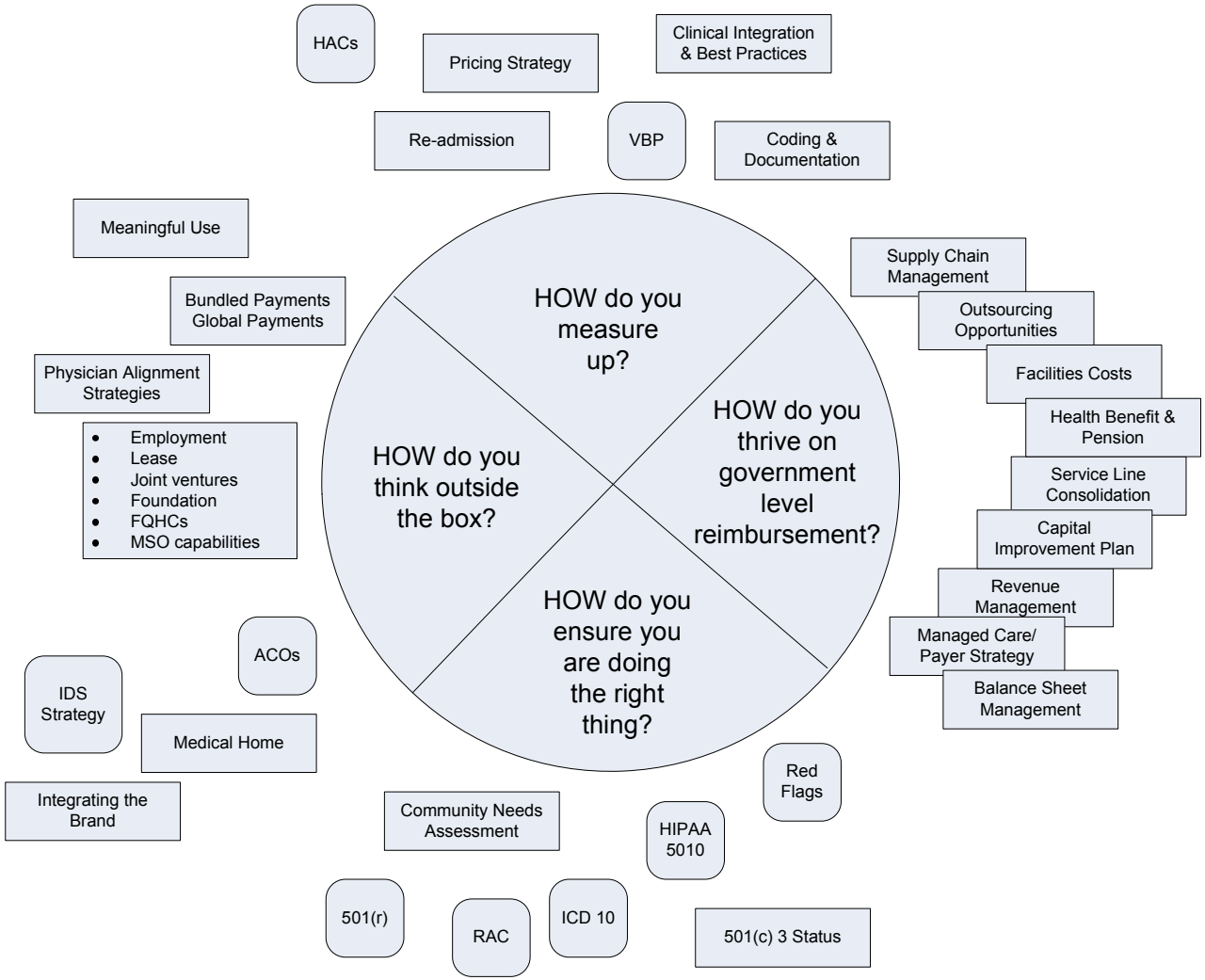
Projected Medicare IPPS Update

Medicare Market Basket Update - Without Reductions for Readmissions, Hospital Acquired Conditions, and Value Based Purchasing								
Federal Fiscal Year	Projected Market Basket Increase	Market Basket Reduction per PPACA[1]	Productivity Adjustment[2]	Behavioral Offset[3] (Case Mix)	Readmissions[4]	Hospital Acquired Conditions[5]	Value Based Purchasing[6]	Total Projected Reimbursement Impact
2011	2.60%	-0.25%		-2.90%				-0.55%
2012	2.10%	-0.10%	-1.30%	-2.90%				-2.20%
2013	2.40%	-0.10%	-1.30%	-1.90%	0%		0%	-0.90%
2014	2.70%	-0.30%	-1.30%	-1.90%	0%		0%	-0.80%
2015	2.90%	-0.20%	-1.30%		0%	0%	0%	1.40%
Total	**12.70%**	**-0.95%**	**-5.20%**	**-9.60%**	**0%**	**0%**	**0%**	**-3.05%**
Projected Market Basket Increase								**12.70%**
Difference Between Market Basket (Inflation) and Update								**-15.75%**

Medicare Market Basket Update - <u>With</u> Reductions for Readmissions, Hospital Acquired Conditions, and Value Based Purchasing								
Federal Fiscal Year	Projected Market Basket Increase	Market Basket Reduction per PPACA[1]	Productivity Adjustment[2]	Behavioral Offset[3] (Case Mix)	Readmissions[4]	Hospital Acquired Conditions[5]	Value Based Purchasing[6]	Total Projected Reimbursement Impact
2011	2.60%	-0.25%		-2.90%				-0.55%
2012	2.10%	-0.10%	-1.30%	-2.90%				-2.20%
2013	2.40%	-0.10%	-1.30%	-1.90%	-1.00%		-1.00%	-2.90%
2014	2.70%	-0.30%	-1.30%	-1.90%	-2.00%		-1.25%	-4.05%
2015	2.90%	-0.20%	-1.30%		-3.00%	-1.00%	-1.50%	-4.10%
Total	**12.70%**	**-0.95%**	**-5.20%**	**-9.60%**	**-6.00%**	**-1.00%**	**-3.75%**	**-13.80%**
Projected Market Basket Increase								**12.70%**
Difference Between Market Basket (Inflation) and Update								**-26.50%**

This information, prepared pursuant to our Engagement Letter dated November 5, 2010, is solely for the use and benefit of Waterbury Hospital and is not intended for reliance by any other person. For discussion purposes only.

The health system of tomorrow will not be the same as today's



This information, prepared pursuant to our Engagement Letter dated November 5, 2010, is solely for the use and benefit of Waterbury Hospital and is not intended for reliance by any other person. For discussion purposes only.

Disclaimer

Our Services were performed and this Report was developed in accordance with our engagement letter dated November 5, 2010 and are subject to the terms and conditions included therein.

Our Services were performed in accordance with Standards for Consulting Services established by the American Institute of Certified Public Accountants ("AICPA"). Accordingly, we are providing no opinion, attestation or other form of assurance with respect to our work and we did not verify or audit any information provided to us. Our work was limited to the specific procedures and analysis described herein and was based only on the information made available through November 2010. Accordingly, changes in circumstances after this date could affect the findings outlined in this Report.

This information has been prepared solely for the use and benefit of, and pursuant to a client relationship exclusively with Waterbury Hospital. PwC disclaims any contractual or other responsibility to others based on its use and, accordingly, this information may not be relied upon by anyone other than Waterbury H.

This document is provided as part of a more comprehensive oral report and is not considered complete without the accompanying oral report.

This information, prepared pursuant to our Engagement Letter dated November 5, 2010, is solely for the use and benefit of Waterbury Hospital and is not intended for reliance by any other person. For discussion purposes only.

EXHIBIT Q5-3

CONFIDENTIAL INFORMATION MEMORANDUM

Confidential Information Memorandum

September 2012

*Memorandum:*_____

CAIN BROTHERS

This Confidential Information Memorandum ("CIM") has been prepared on behalf of Greater Waterbury Health Network, Inc. and its wholly owned subsidiaries and affiliated entities (collectively, the "Company") based on information from the Company and published sources, and is being furnished through Cain Brothers, as the Company's exclusive authorized representative, for informational purposes solely for use by qualified prospects in considering their interest in entering into a partnership, purchase, merger or other form of business combination with the Company (a "Transaction"). The information contained herein is subject to change without notice. Neither the Company nor Cain Brothers assumes any responsibility to update any information contained in this CIM or to inform the recipient of information which may affect this CIM. This CIM has been prepared to assist interested parties in making their own evaluation of the Company and does not purport to be all-inclusive or to contain all information that a prospective party to a Transaction may desire or that may be required in order to properly evaluate the business, prospects or value of the Company. In all cases, interested parties should conduct their own investigation and analysis of the Company and the data set forth in this CIM. Industry data and statistics have been obtained or derived from the Company and published industry sources.

By accepting this CIM, the recipient acknowledges and agrees that all of the information contained herein is highly confidential and subject to the Non-Disclosure Agreement ("NDA") executed by the recipient. Without limiting the generality of the foregoing: (1) the recipient will not reproduce this CIM in whole or in part; (2) if the recipient does not wish to pursue a Transaction relating to the Company, it will (i) promptly return to Cain Brothers hard copies and delete electronic copies of this CIM, together with any other materials relating to the Company which the recipient may have received in written or electronic form from the Company, Cain Brothers or any of their respective subsidiaries or affiliates and (ii) take such other actions, if any, required by the NDA; (3) the recipient will hold all information and the fact that it is involved in any process relating to the Company and the status thereof as confidential; and (4) any proposed actions by the recipient which are inconsistent in any manner with the NDA will require the prior written consent of the Company.

Cain Brothers has not independently verified any of the information contained herein, and neither the Company, Cain Brothers nor any of their respective affiliates makes any representation or warranty (expressed or implied) as to the accuracy or completeness of this CIM or any statements, estimates or projections contained herein. Such statements, estimates and projections reflect various assumptions made by the Company concerning anticipated results, which are subject to business, economic and competitive uncertainties and contingencies, many of which are beyond the control of the Company and which may or may not prove to be correct. As a result, no representation or warranty is made as to the feasibility or attainability of the projected financial information or the accuracy or completeness of the assumptions from which the projected financial information is derived. There can be no assurance that the projections will be realized. This CIM speaks only as of the date hereof or as of the date indicated. This CIM does not constitute an offer or invitation for the sale or purchase of the securities, assets or business described herein. The only information that will have any legal effect will be that specifically represented, warranted and contained in a definitive agreement relating to a Transaction and executed by the Company and a prospective Transaction party. The Company and Cain Brothers disclaim liability for any loss or damage incurred as a result of any information contained in or omitted from this CIM.

The Company reserves the right to negotiate with one or more qualified prospects at any time and to enter into a definitive agreement relating to a Transaction without prior notice to the recipient or other prospective Transaction parties. Further, the Company reserves the right, at any time, to terminate the process and / or to modify any procedures without giving advance notice or providing any reason therefore. The Company also reserves the right during the evaluation period to take any action, whether within or outside the ordinary course of business.

INFORMATION REQUESTS

Cain Brothers is the Company's exclusive financial advisor. Under no circumstances should any interested party directly contact the Company, any of its trustees, employees, medical staff, patients or suppliers, for any reason in connection with their evaluation of the Company. All inquiries regarding this Confidential Information Memorandum or the Company should be directed to the following persons:

James Cain	**Jason D. Horowitz**	**Nichole Kim**
Managing Director	Senior Vice President	Analyst
(212) 981-6955	(212) 981-6951	(212) 981-6919
jcain@cainbrothers.com	jhorowitz@cainbrothers.com	nkim@cainbrothers.com

Cain Brothers & Company, LLC
360 Madison Avenue, 5th Floor
New York, New York 10017
Telephone: (212) 869-5600

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I. Process Overview

A. Organization

Greater Waterbury Health Network, Inc. (together with its affiliates, "GWHN," the "Network," or the "Company") (http://www.waterburyhospital.org) is a Connecticut non-stock, 501(c)(3) corporation. GWHN consists of numerous legal entities, joint ventures ("JVs") and affiliations, including The Waterbury Hospital (the "Hospital" or "Waterbury Hospital"). The Hospital, a 357-licensed bed acute-care teaching hospital provides a comprehensive range of inpatient, outpatient and ancillary services for residents of Waterbury and the surrounding community. The Hospital is located near the intersection of Route 8 and Interstate 84 and currently staffs over 1,250 full-time equivalents ("FTEs"), of which 74 are employed physicians. There are 362 active medical staff members.

B. Objectives

GWHN's Board of Directors (the "Board") has engaged Cain Brothers to explore strategic alternatives, which may include a partnership, merger or sale. At the Board's direction, Cain Brothers is requesting proposals from a select group of organizations interested in a strategic relationship with GWHN. The core objective is to ensure GWHN's continued long-term vigor as a provider of leading health care services to the Greater Waterbury community. As such, GWHN intends to evaluate potential partners who can demonstrably help in achieving the following objectives (the "Objectives"):

- Ensure Waterbury Hospital remains a viable health care entity, providing the highest safety and quality health care services to the Greater Waterbury community for the long-term;
- Provide sufficient capital to meet deferred, current and future capital needs for the Waterbury Hospital physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology;
- Continue a meaningful, local governance presence at Waterbury Hospital that represents both physicians and the Greater Waterbury community;
- Develop and implement an ambulatory service strategy to best position the Company for a successful transition in changing health care delivery methods;
- Develop and implement regional tertiary care relationships for the betterment of health care delivery to the community;
- Deploy repeatable and scalable tools and clinical care services to continually improve the health of the community;
- Enhance the Hospital's medical staff by attracting and retaining physicians through access to available capital partner funds to support such growth;
- Maintain high satisfaction scores by patients, physicians, employees and volunteers; and
- Continue charitable care delivery and funding.

The Board is therefore requesting proposals from a select group of organizations that can demonstrate that they cannot only meet these objectives, but are willing to commit to a shared cultural vision of ensuring cost-effective, high quality care with appropriate charitable care commitments. Further, such organizations will need to demonstrate their ability to complete a transaction within ***a reasonable*** time frame.

C. Recent Events

In August 2011, GWHN entered into a letter of intent, whereby a joint venture would be created with LHP Hospital Group ("LHP") and Saint Mary's Health System ("SMH") (combined, the "JV"). The JV ownership would have been divided among the three parties: LHP with an 80% interest, GWHN and SMH each owning a 10% interest. Governance in the for-profit entity would be shared among all three parties. The JV would have committed to operate its healthcare facilities in accordance with both the community benefit standards applicable to not-for-profit health systems and with the Ethical and Religious Directives for Catholic healthcare services ("ERDs"). Furthermore, as part of the proposed agreement, LHP, through the JV, planned to invest $400 million to construct a new state-of-the-art medical center that would replace both the Waterbury Hospital and SMH hospitals.

After a year of intense negotiations among the parties, community leaders and government officials, it became increasingly clear that there were still many impediments to the transaction. In September 2012, the proposed JV was terminated by LHP. The reasons cited included the increasing costs of building the replacement hospital and the inability to satisfy regulators over issues related to ERDs.

Over the same time period, the competitive landscape in Connecticut changed. Many community hospitals are strategically aligning with stronger, regional partners, consolidating among themselves, or embarking on other strategic initiatives alternatives. For example, Yale-New Haven Hospital acquired the Hospital of Saint Raphael in September 2012. The Western Connecticut Health Network, first developed in July 2010 through the merger of Danbury Hospital and New Milford Hospital, announced in early 2012 that it was exploring a partnership with Norwalk Hospital. Finally, two other organizations, Eastern Connecticut Health Network and Bristol Hospital and Health Care Group recently announced their desire to pursue transactions.

As a result, it has become increasingly important for GWHN to rapidly assess its alternatives for the future.

D. Phase I – Preliminary, Non-Binding Proposals

GWHN, through Cain Brothers, is inviting organizations to ***submit a written, preliminary, non-binding indication of interest and value ("Preliminary Proposals")***, based on the information provided herein and/or related information provided by the GWHN.

Your proposal should be submitted electronically no later than ***5:00 pm Eastern Standard Time on October 12, 2012*** in Microsoft Word® format to Jason D. Horowitz (jhorowitz@cainbrothers.com). Any additional materials supplementing your proposal may be submitted in Adobe PDF® or other electronic format.

After receipt of Preliminary Proposals, GWHN plans to select a limited number of participants to continue to the next round of the process.

GWHN requests that the proposal be as specific and detailed as possible. In order to be considered responsive and to allow for appropriate analysis, proposals should address the elements outlined in Appendix A in the order presented.

Site visits at GWHN facilities, management discussions and limited additional diligence through an established virtual data room will be available prior to the first proposal submission deadline. A Cain Brothers' representative will be available to schedule such requests.

Please do not contact any members of the GWHN's Board of Directors, the Hospital's Trustees, management, or staff without the prior consent of Cain Brothers. Such contact could result in the disqualification for further consideration.

Once received, Cain Brothers will review your proposal and follow-up with any aspects of your proposal that may need elaboration or clarification.

E. Phase II – Detailed Due Diligence and Binding Proposals

Phase II is intended to provide the information that a qualified respondent will need in order to submit a binding proposal. Diligence will primarily be conducted through the GWHN virtual data room, though site visits and meetings with management may be given in select circumstances.

In order to maintain an orderly and consistent flow of information to Phase II participants, any requests for additional due diligence information should be submitted to Cain Brothers in writing or electronically. Cain Brothers will distribute responses to information requests to all Phase II participants.

A binding, definitive proposal will be due following the completion of the due diligence process. This proposal will include a markup of a Definitive Agreement to be provided by GWHN prior to submission of the binding proposal. As soon as feasible, following the submission of a binding proposal, GWHN, with the advice of Cain Brothers and GWHN's legal counsel, will evaluate the proposal to determine if it will be presented to GWHN's Board.

GWHN shall have no obligation to accept any proposal, whether or not such proposal represents the best offer for GWHN. An offer will be accepted only upon the execution and delivery of a Definitive Agreement. Until such time that a Definitive Agreement has been executed, GWHN will not have any obligation to any potential partner with respect to any transaction involving GWHN. Following such time, GWHN's only obligation will be as set forth in a Definitive Agreement.

F. Changes to the Selection Process

GWHN's goal is to identify a candidate with whom to complete a transaction meeting the Objectives as quickly as feasible. Therefore, GWHN expressly reserves the right to consider any and all factors in the selection of a proposal and to deal with any party individually or simultaneously with other candidates. GWHN may alter these and any other procedures, as it deems necessary and appropriate. GWHN also reserves the right, at its sole discretion, to reject any and all expressions of interest or proposals and to terminate the process in its entirety, or with respect to any candidate, at any time.

G. Costs and Expenses

Each participant agrees to bear all costs of its own investigation and evaluation of the operations of GWHN, including the fees and disbursements to its own counsel and advisors. No finders' fees, brokers' fees, or commissions will be paid by GWHN, except to its own advisors, in connection with any transaction which may result.

II. Executive Summary

A. Background

GWHN is a Connecticut non-stock, 501(c)(3) corporation consisting of four (4) active wholly-owned subsidiaries, the largest of which is The Waterbury Hospital. Waterbury Hospital, the first hospital in the City of Waterbury and fourth in the State of Connecticut, opened in 1890, after nearly a decade of fundraising.

The Company's Objectives are to assure GWHN's continued long-term vigor as a provider of leading health care services to the Greater Waterbury community. Based on this overarching goal, GWHN intends to evaluate potential partners who can achieve the Objectives:

- Ensure Waterbury Hospital remains a viable health care entity, providing the highest safety and quality health care services to the Greater Waterbury community for the long-term;
- Provide sufficient capital to meet deferred, current and future capital needs for the Waterbury Hospital physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology;
- Continue a meaningful, local governance presence at Waterbury Hospital that represents both physicians and the Greater Waterbury community;
- Develop and implement an ambulatory service strategy to best position the Company for successful transition in changing health care delivery methods;
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- Enhance the Hospital's medical staff by attracting and retaining physicians through access to available capital partner funds to support such growth;
- Maintain high satisfaction scores by patients, physicians, employees and volunteers; and
- Continue charitable care delivery and funding.

B. Overview

Waterbury Hospital provides a comprehensive range of inpatient, outpatient and ancillary services for residents of Waterbury and the surrounding community. The Hospital is a 357-bed teaching facility located at 64 Robbins Street in Waterbury, Connecticut near the intersection of Route 8 and Interstate 84.

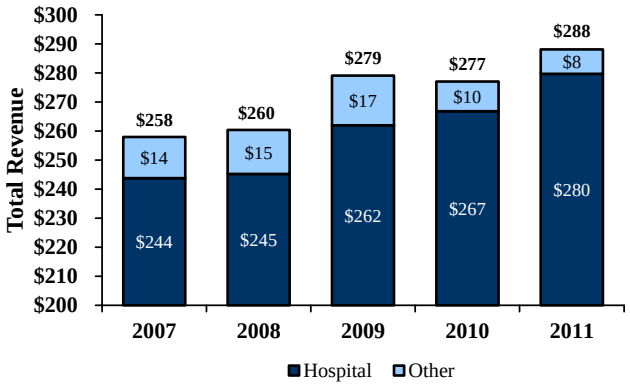
As of August 31, 2012, the Hospital staffs over 1,250 FTEs, including 362 active medical staff members.

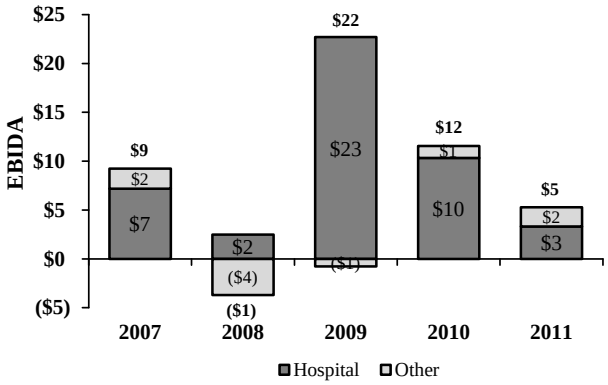
The Hospital and its related subsidiaries, which accounted for 97.1% of the GWHN's revenue in fiscal year ending September 30, 2011, has experienced a compounded annual revenue growth rate of 3.5% over the past four fiscal years.

The Hospital and its related subsidiaries also accounted for 62.6% of GWHN's earnings before interest, depreciation and amortization ("EBIDA") in FY 2011.

Table 2.1: Summary Operating Results

($ in millions)





Note: Fiscal year ends September 30

Table 2.2: Key Hospital Only Utilization Statistics

	2008	2009	2010	2011	For the 10 Months Ended July 31, 2012
Licensed Beds	357	357	357	357	357
Average Length of Stay	4.81	4.86	4.54	4.61	4.71
Inpatient Admissions	14,743	13,928	13,046	12,758	10,251
Patient Days	70,879	67,682	59,271	58,780	48,240
Births	1,287	1,221	1,125	1,124	939
Average Daily Census	194	185	163	161	159

Note: Fiscal year ends September 30

Table 2.3: Hospital and Related Subsidiaries Summary Financial Information

($ in millions)

	Fiscal Year Ended September 30,					
	2007	2008	2009	2010	2011	LTM July 2012
Total Revenue	$243.8	$245.2	$261.9	$266.8	$279.7	$285.0
Total Operating Expenses	248.9	254.5	263.2	270.6	287.2	287.3
EBIDA[(1)]	7.2	2.5	22.7	10.3	3.3	8.7
Operating Income[(1)]	(3.4)	(7.6)	13.1	0.7	(6.0)	(1.0)
Excess Revenue Over Expenses	(4.3)	(8.5)	0.5	(3.8)	(8.5)	(2.9)
Capital Expenditures	4.7	4.1	2.0	5.5	15.6	13.3

Note: Fiscal year ends September 30

(1) Excludes one-time fees including operations improvement expenses

III. Key Investment Considerations

GWHN represents a unique and attractive opportunity for a potential partner to grow in the Southern New England region. GWHN is one of the oldest and well-respected health providers in the Southern New England region, demonstrating leadership, innovation, and high quality service for over a century.

Unique Acquisition Opportunity with Significant Financial Enhancement Potential

GWHN offers a potential partner a well-established system with substantial upside potential. The Hospital represents an excellent opportunity in the Central Connecticut market. While the Hospital has a firmly established market position, it requires additional resources and expertise to further unlock its potential through enhancement of physician recruitment and marketing efforts and leveraging of operational costs, including information technology infrastructure costs and facility upgrades.

- **Physician Recruitment and Service Line Expansion.** Considerable opportunity exists through enhanced physician recruitment efforts to increase patient volumes by expanding specialist recruitment efforts.

- **Low-Cost Provider with Regional Outreach Programs:** GWHN provides a community-based provider platform as a cost efficient solution for potential tertiary / quaternary and other regional high-cost providers. As health care reform takes hold, such service utilization is imperative for creating regional networks and accountable care organizations ("ACOs").

- **Operational Leverage.** A strategic combination with a partner would provide substantial cost saving opportunities from operational expense rationalization and through the leveraging of information technology capabilities that could provide a positive impact on productivity and clinical quality.

- **Facility Upgrade.** Combining GWHN's existing long-term capital plans with an infusion of new capital can substantially increase profitability and top-line growth.

Leading Market Share Position

For several years, the Hospital has maintained the leading market share position in several key areas including obstetrics, behavioral health and musculoskeletal medicine. The Hospital's long-standing relationships with regional physicians and other hospitals have contributed to its overall success, making Waterbury Hospital and its subsidiaries and affiliates, referral sites for many services.

Exceptional Quality, Centers of Excellence and Other Accreditations

The Hospital and its affiliates have received multiple industry accolades for quality, excellent services and operations. Among the distinctions achieved:

- For the past two years, the Hospital was graded in the top 10% nationally by *Healthgrades* in Spinal Surgery
- For the past several years, the Hospital was graded in the top 5% nationally by *Healthgrades* in Orthopedic Joint Replacement
- Consumer Reports ranks Waterbury Hospital as #3 among the Ten Safest Hospitals in Connecticut (2012)

- U.S. News & World Report ranks Waterbury Hospital as #2 among the Best Hospitals in Connecticut (2012)
- Received the American Stroke Association's Get With the Guidelines – Stroke Gold Performance Achievement Award for consistently meeting the highest standards of care for stroke patients (2011)
- Received three-year accreditation by the American College of Surgeons/Commission on Cancer for its cancer program (2011)
- Ranked in the top ten percent in the nation for coronary intervention and received the 2010 Coronary Intervention Excellence Award
- Received accreditation recommendation by the American Society of System Pharmacists for its Pharmacy Residency Program (2010)

Strong Relationships and Partnerships

GWHN is known for its long-standing, meaningful partnerships with local hospitals and physicians for the overall health of the individual organizations and the communities it serves. This practice and philosophy has served GWHN and its partners well, strengthening the services available in Waterbury while enhancing services in regional locations.

Highlights include:

- Access Rehab Centers
- Greater Waterbury Imaging Center
- Harold Leever Regional Cancer Center
- Heart Center of Greater Waterbury

Attractive, but Competitive Market

Waterbury Hospital is located in Waterbury, Connecticut – the fifth largest city in Connecticut and ninth largest city in New England, with an estimated 2011 population of 110,189. The location of the Hospital is extremely advantageous in providing access via major transportation routes (Interstate 84 and Connecticut Route 8) and is visible from all around as it is located above city center.

Known as the "Brass City," the area once bustled as the home of the nation's only skilled brass craftsmen. But as the city developed, the brass industry left and a new, more modern and skilled labor force took hold. Industrial parks replaced the former brass mills and new businesses continue to relocate to the city. Today, service and retail trade industries are Waterbury's predominant players.

Waterbury's total population has remained fairly consistent in the past two decades, hovering near the 110,000 mark. Close to 80.0% of the population has at least a high school diploma, and almost half the population is in their prime earning years (25 – 55). Waterbury's unemployment is higher than the national trend.

For the past 100 years, Waterbury's health care needs have been served by two hospital systems, GWHN and SMH. While the two have attempted to merge all their operations three times in the past, (including this past year), the two institutions have been unable to successfully consummate a transaction. However, SMH and GWHN continue to work collaboratively on several initiatives, including the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury.

IV. Network and Hospital Overview

A. Network and Hospital Introduction

GWHN is a Connecticut non-stock, 501(c)(3) corporation consisting of four (4) active wholly-owned subsidiaries, the largest of which is The Waterbury Hospital**.** GWHN employs over 1,250 FTEs and is the second largest employer in Waterbury.

GWHN's mission is "To support and encourage the development of comprehensive, integrated, healthcare related services for the advancement of the health and well-being of the general public by providing financial, management and other assistance to its affiliates including Waterbury Hospital."

Waterbury Hospital, the first hospital in the city of Waterbury and fourth in the state of Connecticut, opened in 1890, after nearly a decade of fundraising. The original home was in a Victorian mansion overlooking the city. During its first twelve months of operation, 85 patients were admitted and two babies were born. The staff included eight physicians, ten nurses, one orderly, a janitor and a cook. Although there was hot and cold water, all operations were performed by daylight, since the light bulb had not yet been invented.

The Hospital, a wholly owned subsidiary of the Network, is a community teaching hospital located in the northern section of New Haven County, between Hartford and New York City. Its mission is "To provide compassionate, high quality health care services through a family of professionals and services." The Hospital is licensed for 357 beds and currently staffs approximately 190 beds excluding bassinets.

Table 4.1: Beds by Service Line

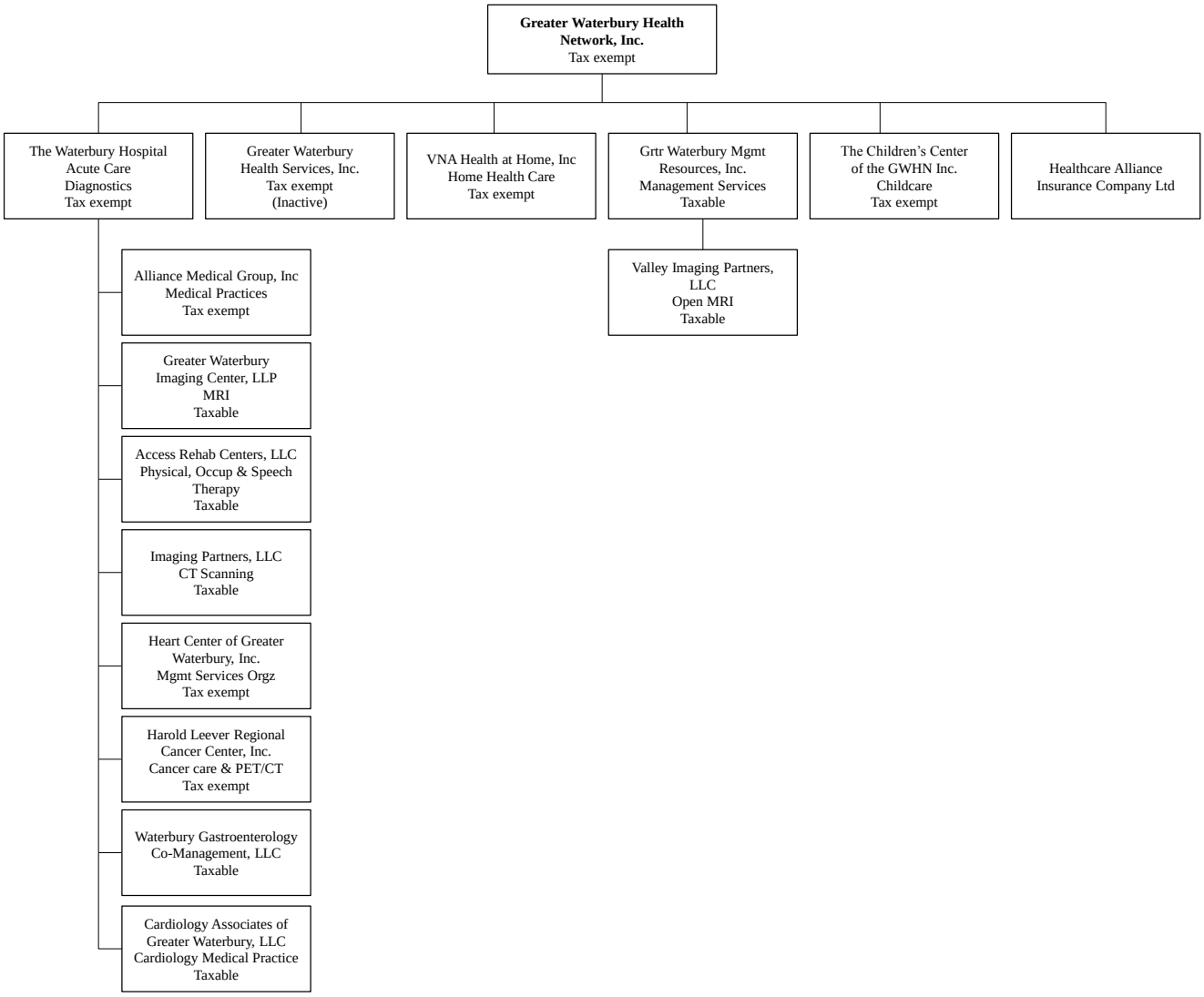
Service	Licensed Beds	Staffed Beds
Medical/Surgical	265	118
ICU / CCU	40	24
Psychiatry	30	30
Obstetrics	22	18
Sub-Total (Acute)	**357**	**190**

The Hospital is also a Connecticut non-stock corporation, exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code. A voluntary Board of Trustees elected by the Network governs the Hospital. The Hospital's Board of Trustees consists of individuals selected for their leadership and community interest who serve for a maximum of 12 years.

B. Affiliations and Partnerships

Set forth below is the organizational structure of the entities within the Company:

Table 4.2: Greater Waterbury Health Network



GHWN is the sole member or sole equity holder, as the case may be, of the following entities:

- **<u>The Waterbury Hospital (wholly-owned, 100%).</u>** The Hospital operates as an acute care teaching hospital under the direction of its Board of Trustees. (*Please see the following Section "C. Hospital Overview" for an overview of Hospital Services.)*

    - **<u>Alliance Medical Group Inc. (wholly-owned, 100%).</u>** Alliance Medical Group ("AMG") is a tax exempt 501(c)(3) medical foundation and a wholly owned subsidiary of the Hospital. AMG is the largest hospital-affiliated, multi-specialty group in the Waterbury area with more than 100 physicians and health care providers practicing in the following specialties: Internal

Medicine, Pediatric and Adolescent Medicine, Breast Surgery, General and Colorectal Surgery, Endocrinology, Pulmonary, Rheumatology, Infectious Disease/Travel Medicine and Sleep Medicine. AMG uses an electronic medical record ("EMR") system that allows all physicians access to their patients' medical records to streamline and coordinate care.

- **Greater Waterbury Imaging Center Limited Partnership (64% owner).** The Hospital is the general partner of Greater Waterbury Imaging Center Limited Partnership (the "Limited Partnership"), a Connecticut limited partnership formed to develop and operate a medical diagnostic imaging center. The Limited Partnership was formed in 1988. The imaging center, which is adjacent to the Hospital's Emergency Department, is in a building constructed by the Hospital and leased to the Limited Partnership. The Limited Partnership agreement does not commit the Hospital to fund any operational or capital deficits.

- **Access Rehab Centers LLC (65% owner).** Access Rehab Centers LLC ("Access") is a limited liability company formed in 1998 and owned by the Hospital and Easter Seal Rehabilitation of Greater Waterbury, Inc. It offers the region's largest and most comprehensive array of outpatient physical, occupational and speech therapy to adults and children. Access also provides physical therapy services on an inpatient basis to Waterbury Hospital. The two main facilities, located at 134 Grandview Avenue and 22 Tompkins Street, specialize in pain management, neurologic rehabilitation and therapies aimed at returning the patient to the work place. Access has nine additional outpatient locations serving the surrounding community.

- **Imaging Partners LLC (85% owner).** Imaging Partners LLC is a limited liability company owned by the Hospital and a private radiology practice, Diagnostic Radiology Associates, LLC. Formed in 2001, Imaging Partners offers advanced, multi-slice CT scanning services. Located at 134 Grandview Avenue in Waterbury in a convenient medical office building setting, this partnership is a key component of Waterbury Hospital's outpatient imaging network.

- **Waterbury Gastroenterological Co-Management Company, LLC.** Waterbury Gastroenterological Co-Management Company, LLC, is a limited liability company established to provide management services to Waterbury Hospital to improve and, where appropriate, maintain the overall quality, efficiency, and effectiveness of the Hospital's gastroenterology service line. The Hospital is the sole Class H Member and has certain management rights; the Physician owners, Class P Members, assist the Hospital in providing such management services.

- **Cardiology Associates of Greater Waterbury, LLC.** Cardiology Associates of Greater Waterbury, LLC is a cardiology practice established in 2010 and owned by the Hospital. The practice is comprised of eight employed board certified cardiologists, three of whom are interventional cardiologists. The practice has approximately 20,000 active patients.

- **Greater Waterbury Health Services (wholly-owned, 100%).** Greater Waterbury Health Services, Inc., a not-for-profit corporation, was organized to provide for the contracting and management of tax-exempt community health services and programs in which GWHN may engage. Currently, there is no activity in this subsidiary.

- **VNA Health at Home (wholly-owned, 100%).** VNA Health at Home, Inc., ("VNA") is a non-profit, non-stock corporation established in 1939 and affiliated with the Company since 1996. VNA is a home health care agency that provides skilled nursing care, speech, physical and occupational therapy and medical social work throughout the Greater Waterbury region.

- **Greater Waterbury Management Resources (wholly-owned, 100%).** Greater Waterbury Management Resources, Inc. ("GWMRI"), of which the Network is the sole stockholder, is a taxable corporation. GWMRI is a Medical Service Organization originally organized to provide services to effectively manage medical group practices. While GWMRI has been in existence since 1984, there is minimal activity since the formation of and transition to AMG.

- **Children's Center (wholly-owned, 100%).** Children's Center of Greater Waterbury Health Network, Inc., ("CCGWHN") a not-for-profit tax exempt corporation, is a nationally accredited state-licensed childcare center. CCGWHN provides a staff of early childhood professionals to care for children from six weeks to five years of age and has been providing childcare services since 1997.

- **Healthcare Alliance Insurance Company (33% owner).** Healthcare Alliance Insurance Company, Ltd. ("HAIC") is a Cayman Islands based captive insurance company owned jointly by Griffin Health Services, Milford Health and Medical, Inc., and The Greater Waterbury Health Network, Inc. HAIC was created to offer professional malpractice and general liability insurance coverage to Griffin Hospital, Milford Hospital, and Waterbury Hospital, and members of their respective medical staffs. The Network became a shareholder in 2006 with 33% ownership.

  In addition to the above subsidiaries, the Hospital has two 50/50 Joint Ventures with Saint Mary's Hospital providing specialty services:

  - **Harold Leever Regional Cancer Center.** Harold Leever Regional Cancer Center, Inc. ("HLRCC"), a 501(c)(3) corporation, is a 50 / 50 JV between the Hospital and Saint Mary's. Formed in October 2002, HLRCC combined both hospitals' existing medical and radiation oncology businesses into one combined program to better meet the needs of the community. HLRCC provides state of the art cancer diagnostic and radiation services with two (2) linear accelerators and a PET/CT Scanner. Located at 1075 Chase Parkway, Waterbury, the building is also home to the area's two private medical oncology practices.

  - **Heart Center of Greater Waterbury.** Heart Center of Greater Waterbury ("HCGW"), a 501(c)(3) corporation, is a 50 / 50 JV between the Hospital and Saint Mary's. Under this joint program, the two hospitals are able to provide area residents with advanced cardiac services, including cardiac angioplasties and open heart surgery on both hospitals' campuses. The program performs over 650 angioplasties and 200 open heart surgeries annually.

C. Hospital Overview

Waterbury Hospital provides a variety of health care services including:

- **Orthopedic Services.** Waterbury Hospital, one of the busiest orthopedic centers in New England, receives high marks for outstanding clinical quality, performance and excellence in orthopedics, with special recognition for joint replacement surgery and spinal surgery. The Hospital's orthopedic surgeons specialize in providing diagnosis, treatment and rehabilitation for patients experiencing injury or disease of the bones, muscles, tendons, ligaments and nerves.
    - **The Joint Replacement Center.** The surgeons and staff at the Joint Replacement Center specialize in innovative surgical treatment for patients with knee and hip arthritis, treatment options and replacement options. The center performs more than 900 hip and knee replacements or revisions annually, making it one of the busiest orthopedic centers in the state.
    - **The Shoulder Center.** The Shoulder Center provides evaluation and management of shoulder injuries by experienced, fellowship-trained orthopedic surgeons. High-quality musculoskeletal radiologists, experienced OR teams, a full complement of advanced arthroscopic instrumentation and state-of-the-art rehabilitation combine to make the Hospital a regional leader in shoulder care
    - **Spine Care.** Waterbury Hospital provides care for individuals with a wide range of back and neck problems.
    - **Sports Orthopedics.** Sports Orthopedics uses the most advanced sports medicine and orthopedic practices, protocols and treatments to help patients return to sports. The physicians specialize on the hand, wrist, arm, elbow, foot and ankle.
- **Behavioral Health.** Behavioral Health of Waterbury Hospital employs a multidisciplinary approach and encourages the client to be an active participant in treatment. Through a blending of biologic and psychosocial modalities, the Hospital endeavors to reduce distress, to educate and to heal. The Hospital utilizes state-of-the-art therapies that assist patients in achieving their goals in a manner that preserves privacy and promotes personal dignity and hope. Whenever possible, the Hospital seeks to reduce the stigma associated with mental illness and to promote compassion and understanding.
    - **The Center for Behavioral Health.** Completed in 1997, The Center for Behavioral Health offers state-of-the-art treatment in a therapeutic environment. Located in the Pomeroy Pavilion at the Hospital, the Center for Behavioral Health features specialized units for the treatment of adolescents, adults and older individuals. The treatment team includes psychiatrists, psychologists, social workers, nurses, occupational therapists,

activity therapists and other mental health professionals working collaboratively with patients, families and providers.

- **Chemical Dependence & Dual-Diagnosis Services.** The program offers a range of options for people who have problems with alcohol, opiates, cocaine, cannabis, sedatives and other substances. The treatment team consists of nurses, substance abuse counselors and physicians. The multi-dimensional approach to chemical dependency incorporates medical, behavioral, motivational and harm-reduction strategies.

- **Child and Adolescent Services.** This partial hospital program provides daily intensive treatment in a structured environment. Treatment centers on the child/adolescent at risk and their families and other support systems. Therapies include group, individual and family, as well as other more specialized modalities such as anger management, creative expression, school issues forum, substance abuse treatment and separate male and female treatment groups. Multiple family meetings are offered in both the Partial Hospital Programs and Intensive Outpatient Programs. Intensive Outpatient Programs embrace a broad range of therapeutic techniques designed to assist children / adolescents and their families to work in an intensive and goal-focused manner.

- **Crisis Assessment and Triage Services.** The Crisis Assessment and Triage Service provide easy access to the entire continuum of behavioral health services at the Hospital. These services are available 24 hours per day, seven days per week. Appointments are available within 24 hours; however, clients may also be seen on an emergent/urgent basis.

- **The Comprehensive Center for Arthritis.** The Comprehensive Center for Arthritis specializes in the evaluation and treatment of patients with arthritis and other rheumatologic diseases. The physicians and staff provide diagnostic evaluations, ongoing care for patients with chronic rheumatologic problems and education to patients and their families. Patients also benefit from the physical, occupational and speech therapy services at Access Rehab Centers of Waterbury Hospital.

- **Emergency Services.** The Hospital is a Level II Trauma Center providing optimal care for all critically ill or injured patients.

- **The Family Birthing Center.** The Family Birthing Center offers 24 hour in-house obstetrics and anesthesia coverage by board certified physicians with years of experience. The Hospital's board certified neonatologists and CCMC mid-level practitioners are available to evaluate babies at birth. The neonatal intensive care unit ("NICU") is staffed with specially trained nurses and lactation counselors.

The NICU is a Level II nursery, which cares for babies at 28 weeks gestation and has relationships with tertiary centers if needed. The Family Birthing Center also provides Certified Nurse Midwife service allowing a low-intervention birth in a family-focused environment.

- **Henry S. Chase Outpatient Center.** The Henry S. Chase Outpatient Center offers general primary health care to individuals living in Greater Waterbury. Physicians, registered nurses and allied health professionals also provide orthopedic, surgical, urology, menopause, dermatology, gastroenterology, podiatry and musculoskeletal specialty services.

- **Hospitalist Program.** The Hospitalist Program provides patients with coordinated, seamless care during their stay at the Hospital. Hospitalists are licensed medical doctors, trained in internal medicine, who devote their practice to the unique needs of hospitalized patients. Hospitalists oversee a patient's care from admission to discharge. The hospitalists care for patients around-the-clock and work with private doctors to deliver the right care at the right time and are able to respond quickly and efficiently to changes in a patient's condition that may require a new medication, test or procedure.

- **Intensive Care / Telemetry.** A 20-bed Intensive Care unit and a 30-bed Telemetry unit combines a highly skilled nursing staff with the state-of-the-art technology necessary to meet the needs of patients. A centralized monitor watcher program maximizes the staff's ability to track patients closely. The units are an integral component of the Hospital's designation as a Level II Trauma Center.

- **Laboratory Services.** The Hospital operates nine blood drawing facilities in Waterbury, Middlebury, Naugatuck, Southbury, Thomaston, Watertown and Woodbury.

- **Medical Library.** The library is located on the first floor of the Hospital's North Wing and extends its services to patients, families, the community, and hospital-affiliated physicians, residents and students.

- **Medical Residency Program.** The Hospital is home to a robust medical residency program that is sponsored by the Yale School of Medicine and has the distinction of being the single, major community hospital training site for the Yale School of Medicine's Primary Care and Internal Medicine Residency Program. Since 1989, over 200 doctors have trained in the program. Since the program's inception, over 90 of these residents have continued to practice in Connecticut. Seven Alliance Medical Group primary care internists have trained in the Waterbury Hospital based program.

- **Outpatient Testing.** Outpatient Testing is located on the ground floor and provides testing including clinical laboratory testing, autologous donation services, EKG testing and preoperative assessments and instructions. It offers convenience by enabling patients to complete their testing needs in one convenient location.

- **Pharmacy Program.** The Hospital offers a PGY-1 clinical Pharmacy Residency Program and is accredited by the American Society of Health-System Pharmacists ("ASHP") with two resident positions available each year. The Hospital also participates in the Resident Match Program.

- **Reed Cardiology.** The Reed Cardiology Department provides cardiac and pulmonary patients with exceptional, individualized medical services from diagnostic to rehabilitation. The staff consists of cardiologists, registered and practices nurses, nurses, physical and respiratory therapists and technicians, invasive and non-invasive cardiopulmonary technicians, exercise specialists, as well as registered echocardiography, nuclear medicine and EKG technicians**.**

    - **Invasive Cardiac Testing and Intervention.** Services include cardiac catheterization and coronary angioplasty/stent.

    - **Non-Invasive Heart Testing.** Services include echocardiogram, trans-esophageal echocardiogram, treadmill stress testing, nuclear stress testing, pulmonary function test, exercise physiology test, holter monitory and pacemaker clinic.

    - **Cardiopulmonary Rehabilitation.** Twenty-four hour patient monitoring and extensive wellness and rehabilitation services for cardiac and pulmonary patients are also offered. Services include inpatient cardiac rehabilitation (phase I), outpatient cardiac rehabilitation (phase II), cardiac rehabilitation (phase III), Volunteer Visitation Program and Healthy Hearts Club.

- **The Reed Surgery Center.** The Reed Surgery Center ("Reed") is equipped with the latest surgical instrumentation, including minimally-invasive technology. There are approximately 6,000 out-patient surgeries a year at the Hospital. One Day Surgery routinely handles general, gynecological, and orthopedic procedures, as well as all non-surgical procedures and post-operative care, including liver biopsy, cardioversion, anesthesia procedures, bronchoscopy, arteriogram preparation and recovery, cardiac catheterization recovery and MRI and CT-Scan sedation.

- **Sleep Lab.** The facility is dedicated to sleep disorders through sleep consultations and customized treatments. More than 30 percent of individuals suffer from a sleep-related problem which may include severe snoring sleep apnea, restless legs syndrome, narcolepsy and insomnia. Sleep disorders can result in a wide range of problems including worsening of depression, high blood pressure, ADHD in all ages and increased risk of coronary artery disease. The Sleep Lab has one off campus location in Middlebury.

- **Surgical Residency Program.** The Hospital's surgical residency program is one of the few remaining independent surgical residency programs in the country, providing a full spectrum of surgical experiences for its trainees. The Hospital's residents have access to general surgery, ENT, urology, plastics, GYN, neurosurgery and orthopedic cases. As a Level II Trauma facility, they also receive education and experience in the trauma specialty. The Surgical Residency Program also trains medical students from the University of Connecticut School of Medicine and PA students from Quinnipiac University. The residents rotate at Yale New Haven Hospital, Hartford Hospital and Connecticut Children's Medical Center. Over 60 years old, the surgical residency program has graduated over 120 surgeons, many of whom have accepted prestigious fellowship appointments at prominent hospitals across the country. Four of the five surgeons in Alliance Medical Group have trained in the Waterbury Hospital based program.

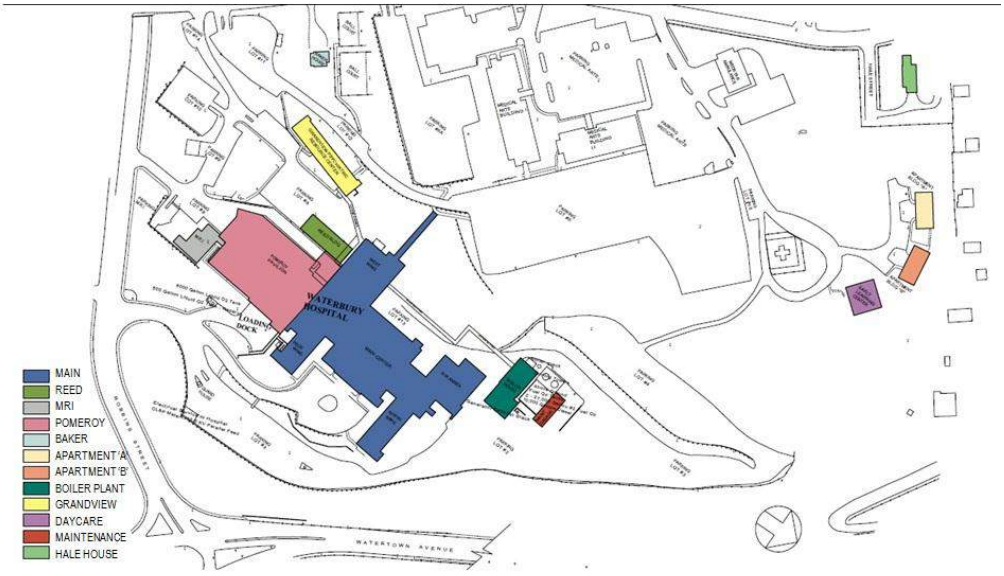
  The Stroke Center. The Hospital is certified by the Connecticut Department of Public Health as a Primary Stroke Center. Waterbury Hospital provides the very latest and best treatment options for stroke victims. The Stroke Center team treats patients who have had strokes and TIAs (transient

ischemic attacks) by providing emergency stroke treatment, as well as education for hospital inpatients and the community on stroke risk factors and warning signs, stroke prevention and rehabilitation.

D. Facilities

The Hospital campus is located on 38 acres in the west side of Waterbury at the cross roads of Route 8 and Interstate 84. The lower campus, accessed from Robbins Street, is home to the main hospital facilities, including inpatient, outpatient and emergency services. The Pomeroy Pavilion houses all of the inpatient services. The Reed Surgical Center is a state of the operating suite where advanced cardiac surgery is performed. The upper campus, accessed from Grandview Avenue, offers a suite of Medical Offices as well as the Children's Center and helipad. Also accessed from Grandview Avenue is the outpatient Behavioral Health Services. The Development Office sits adjacent to the upper campus.

Table 4.3: Waterbury Hospital Facility Map



The Hospital consists of 12 floors, with additional lower and ground levels. The following tables are representative floor plans of several of the floors:

Table 4.4: Waterbury Hospital Facility Map – Lower Level

Table 4.5: Waterbury Hospital Facility Map – Ground Floor

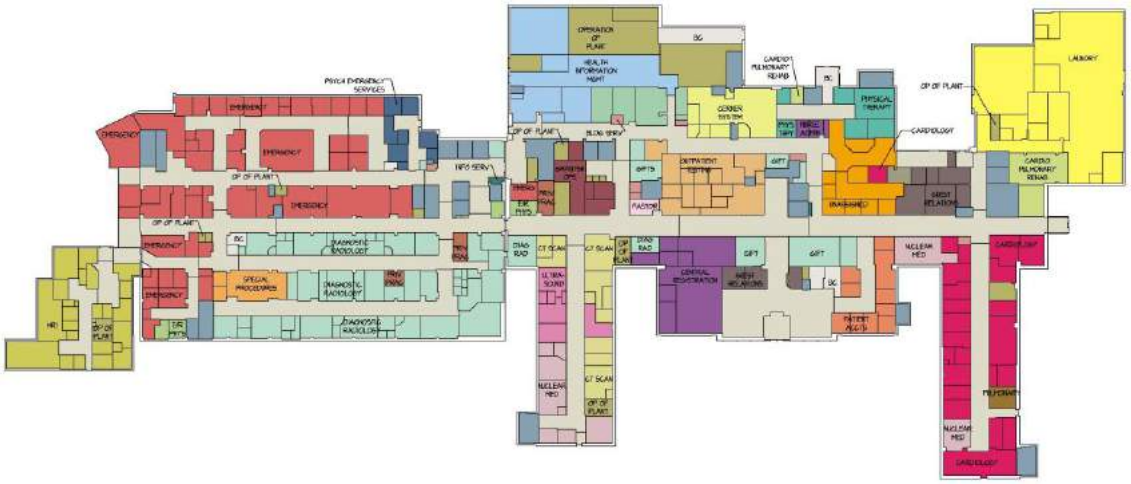


Table 4.6: Waterbury Hospital Facility Map – First Floor

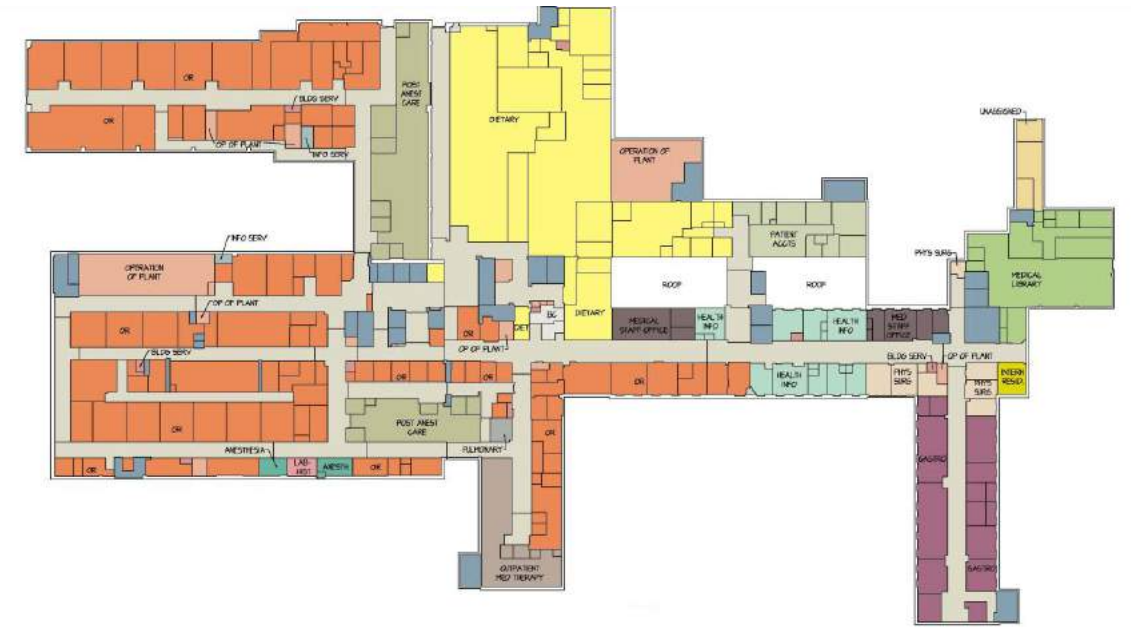


Table 4.7: Waterbury Hospital Facility Map – Second Floor

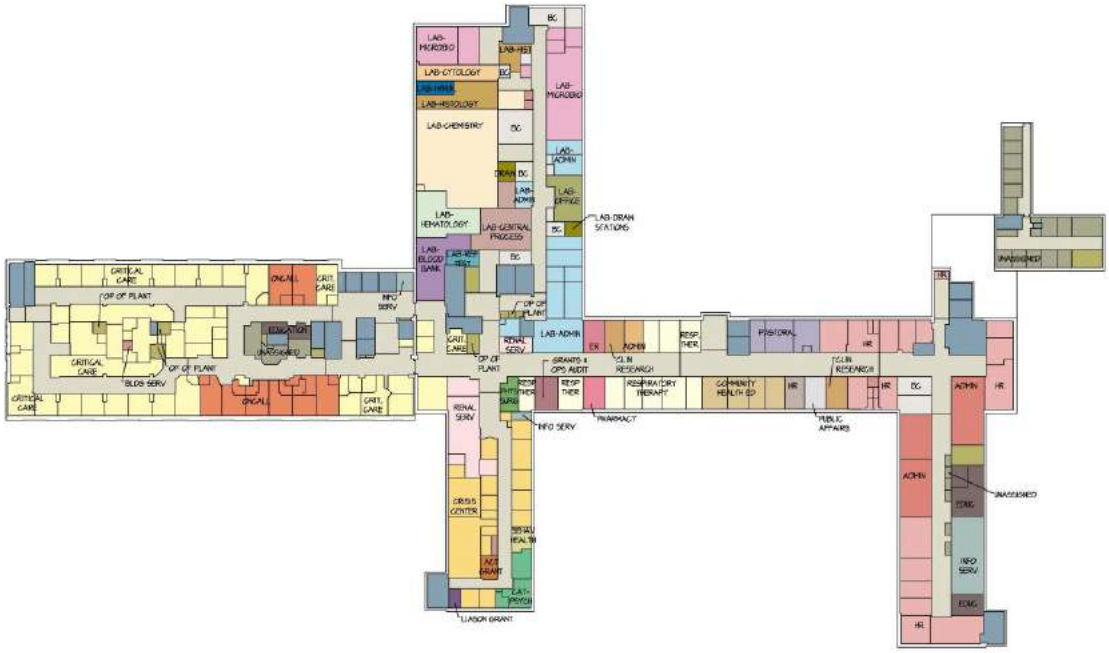


Table 4.8: Waterbury Hospital Facility Map – Third Floor

Table 4.9: Waterbury Hospital Facility Map – Fourth Floor

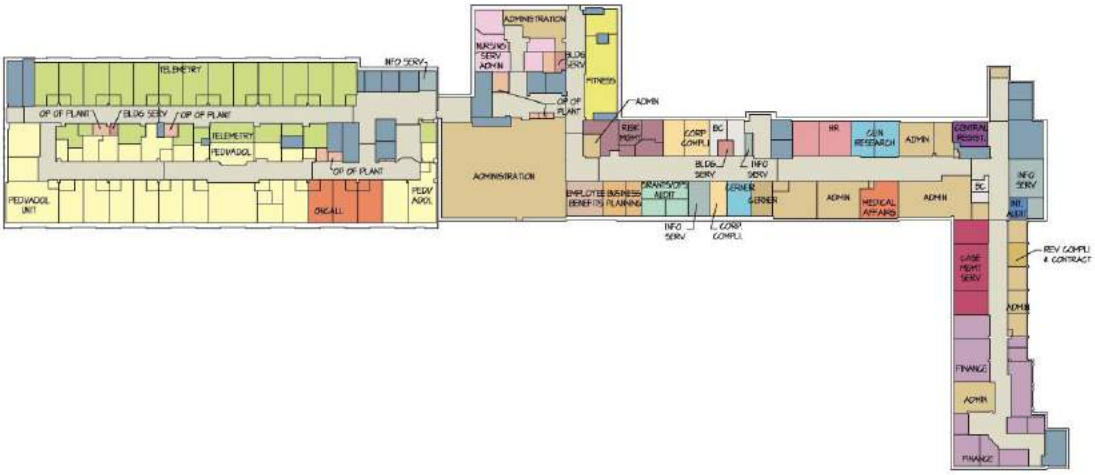


Table 4.10: Waterbury Hospital Facility Map – Fifth Floor

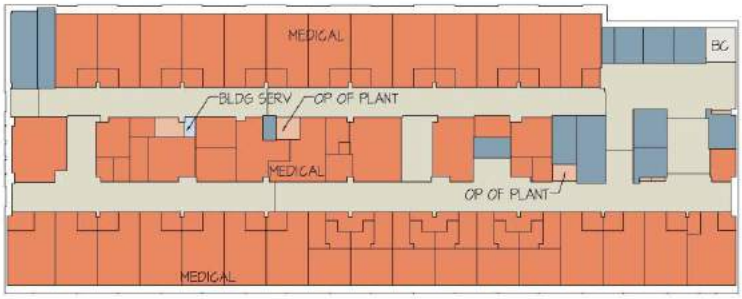


Table 4.11: Waterbury Hospital Facility Map – Sixth Floor

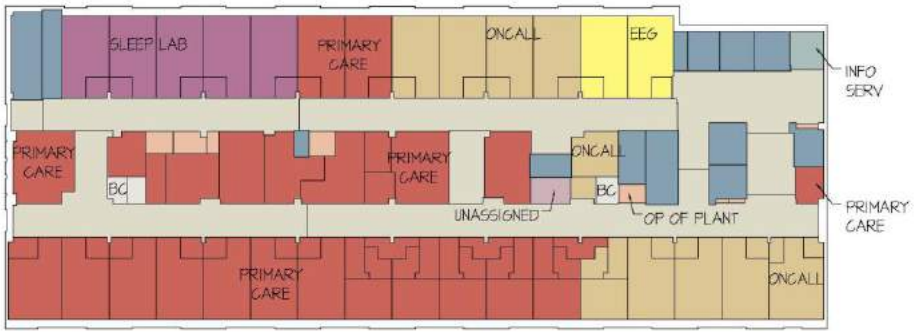


Table 4.12: Waterbury Hospital Facility Map – Seventh Floor

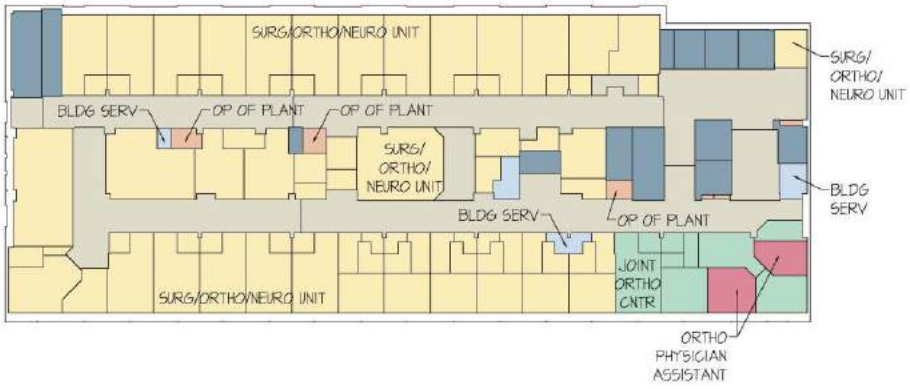


Table 4.13: Waterbury Hospital Facility Map – Eighth Floor

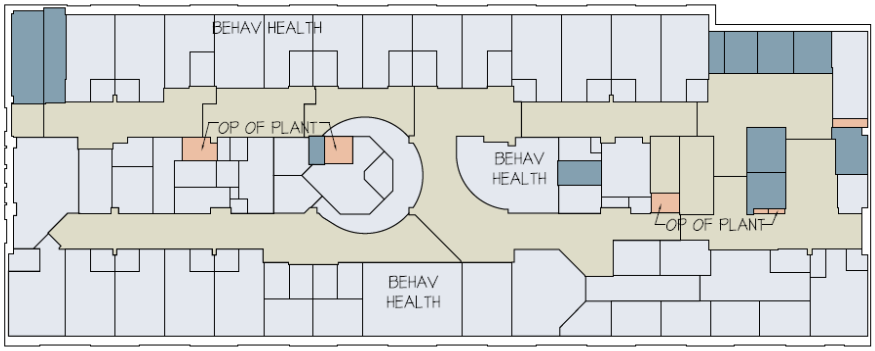


Table 4.14: Waterbury Hospital Facility Map – Ninth Floor

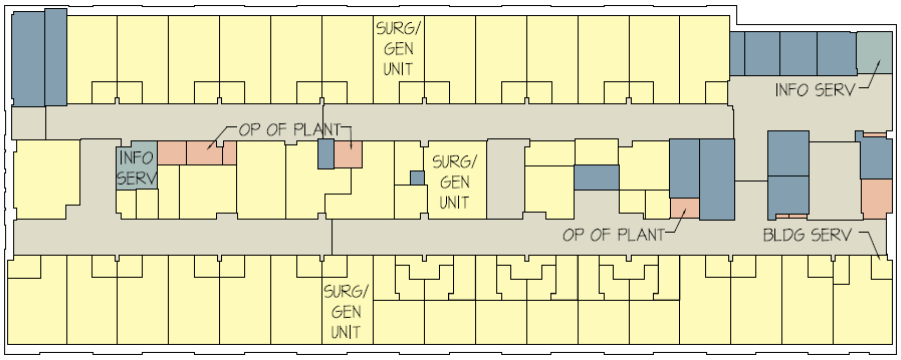
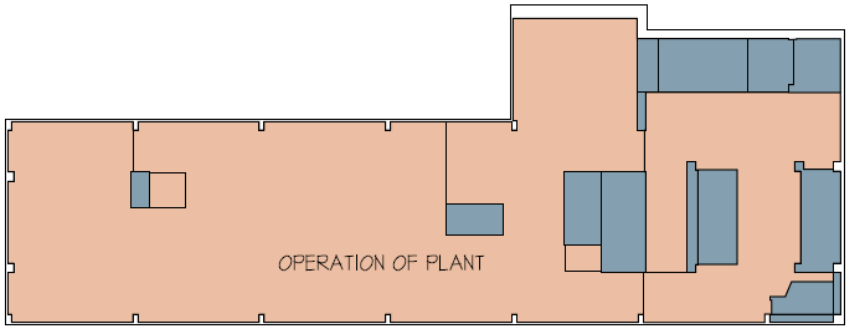


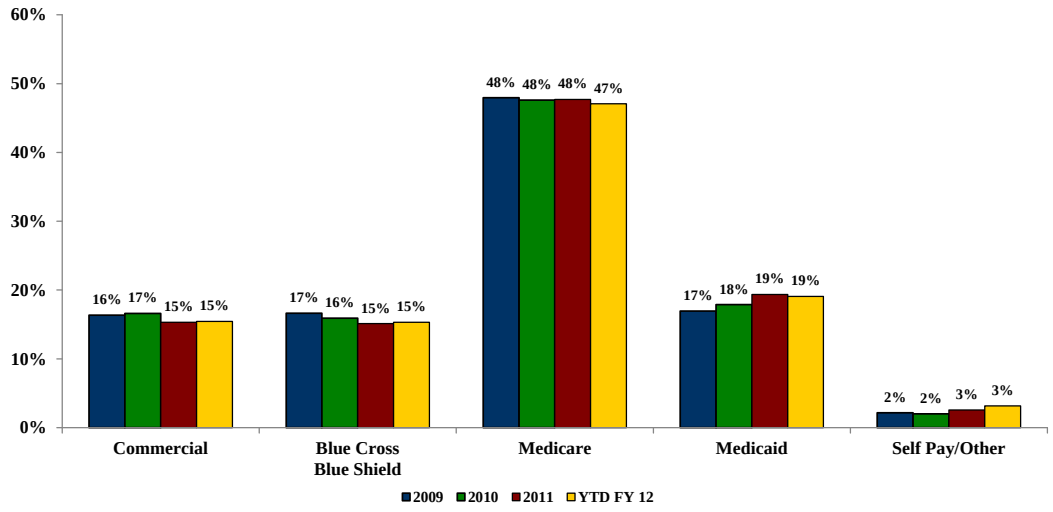
Table 4.15: Waterbury Hospital Facility Map – Tenth Floor



E. Payor Mix

The Hospital's payor mix has remained relatively steady since 2007. The Hospital's historical payor mix is as follows:

Table 4.16: Waterbury Hospital Historical Payor Mix (by Gross Revenue)



Note: Fiscal year ends September 30

The Hospital's payors are comprised primarily of Commercial, Blue Cross Blue Shield and government payors including Medicare and Medicaid.

- **Commercial.** The Hospital has contracts with PPO and/or PPO/HMO/POS managed care organizations that account for about 15% of the Hospital's payor mix.

- **Blue Cross Blue Shield.** The Hospital contracts with Anthem Blue Cross Blue Shield, which comprises about 15% of the Hospital's payor mix.

- **Medicare.** The Hospital's Medicare revenues are generated through both traditional and Medicare Advantage programs. Medicare comprises about 47% of the Hospital's payor mix. As the population continues to age, the Hospital expects to see a continuing increase in Medicare's portion of the payor mix, along with a corresponding increase in the losses associated with the provision of this care.

- **Medicaid.** The Hospital's Medicaid revenues are derived from Aetna Better Health, AmeriChoice, CHN, State Medicaid and Medicaid LIA. Overall, Medicaid comprises about 19% of the Hospital's payor mix.

- **Self Pay/Other.** The uninsured patient population and other payors comprise about three percent of the Hospital's payor mix.

F. Utilization Statistics

The Hospital's historical utilization statistics are as follows:

Table 4.17: Waterbury Hospital Only Utilization Statistics

	2009	2010	2011	For the 10 Months Ended July 31, 2012
Inpatient Admissions				
Adults & Children	12,707	11,921	11,634	9,312
Newborns	1,221	1,125	1,124	939
Total	13,928	13,046	12,758	10,251
Patient Days				
Adults & Children	63,850	55,788	55,209	45,258
Newborns	3,832	3,483	3,571	2,982
Total	67,682	59,271	58,780	48,240
Average Length of Stay (days)				
Adults & Children	5.02	4.68	4.75	4.86
Newborns	3.14	3.10	3.18	3.18
Average	4.86	4.54	4.61	4.71
Daily Patient Census				
Adults & Children	175	153	151	149
Newborns	10	10	10	10
Total	185	162	161	159
Percent of Occupancy (Based on staffed beds)	96.08%	85.79%	84.76%	97.75%
Ambulatory Surgery Cases	4,513	4,504	4,644	4,081
Emergency Department Visits (Inpatient and Outpatient)	58,561	58,443	57,816	47,180
Patient Care Services				
CT Scans	22,435	21,253	17,829	12,996
Drug Orders Dispensed	1,876,529	1,474,965	1,442,901	1,417,420
EEG Exams	2,510	2,193	1,759	1,554
EKG Exams	30,350	29,466	30,975	25,154
Laboratory tests	1,168,999	1,090,040	1,114,691	947,411
Meals served to patients	170,918	167,364	165,627	135,774
Nuclear medicine treatments (contains drugs)	12,719	9,098	8,949	6,552
Psychiatric visits	29,060	27,272	27,297	24,065
Pulmonary disease treatments	83,186	73,746	71,887	60,202
Surgical operations	8,680	7,776	7,517	6,228
Ultrasound exams	8,996	9,267	9,128	7,207
X-ray exams	52,250	48,358	46,298	36,134

Note: Fiscal year ends September 30

G. Procedure Mix

The Hospital provides a wide breadth of services to the community. Its procedure mix is as follows:

Table 4.18: Waterbury Hospital Only Historical Procedure Mix – Inpatient Cases

	2009	2010	2011	For the 10 Months Ended July 31, 2012
Medical*	5,332	4,941	4,963	4,044
Medical Cardiology	1,517	1,340	1,408	1,149
Newborn	1,230	1,129	1,126	940
Maternity	1,202	1,114	1,109	925
Mental Disease/Substance Abuse	794	916	860	790
Surgical	1,074	960	947	692
Major Joint	958	963	724	499
Ortho	423	404	384	305
Angioplasty	334	339	366	223
Surgical Cardiology	277	249	207	179
Neurosurgery	145	135	152	157
Ortho Nonsurgical	161	142	154	118
Urology	228	180	178	145
Gynecology	253	234	176	85
Total Cases	**13,928**	**13,046**	**12,754**	**10,251**

Source: Company Reports
Note: Fiscal year ends September 30
**Includes pediatric inpatient cases*

Table 4.19: Waterbury Hospital Only Historical Contribution Margin – Inpatient Cases

	2009	2010	2011	For the 10 Months Ended July 31, 2012
Surgical Cardiology	$7,466	$5,422	$5,193	$6,986
Major Joint	5,484	7,513	7,066	6,269
Ortho	4,288	7,187	3,617	6,055
Surgical	6,350	7,502	5,960	5,760
Neurosurgery	7,367	6,539	8,739	5,691
Medical*	4,179	4,473	3,843	3,795
Angioplasty	6,232	4,309	2,739	3,623
Medical Cardiology	3,709	3,830	2,926	2,911
Mental Disease/Substance Abuse	2,097	2,112	1,816	2,732
Ortho Nonsurgical	2,437	3,338	3,928	2,657
Urology	4,144	3,848	3,642	2,468
Newborn	1,600	878	913	1,423
Gynecology	1,419	1,669	1,365	910
Maternity	1,335	262	981	704
Inpatient Contribution Margin / Case	**$3,873**	**$4,066**	**$3,396**	**$3,463**

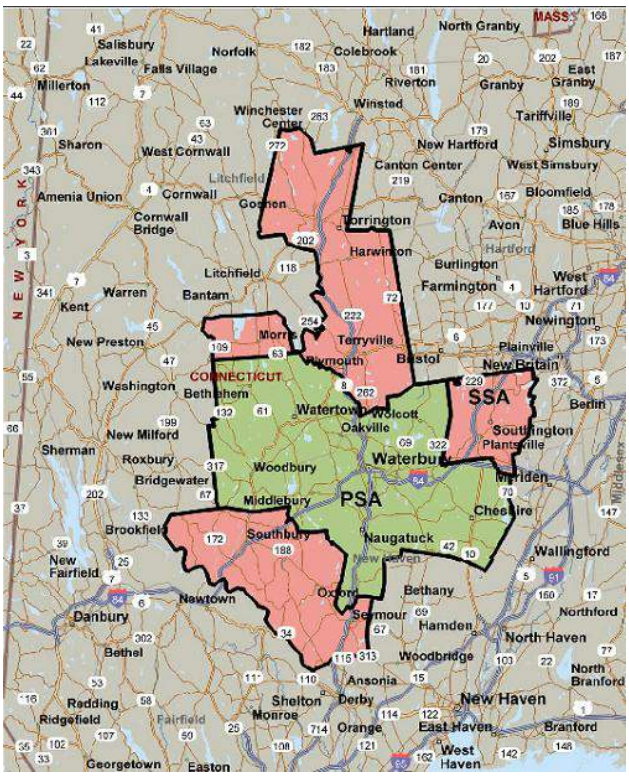
Source: Company Reports
Note: Fiscal year ends September 30
**Includes pediatric inpatient cases*

V. Service Area Profile

The Hospital's primary service area, with a total population of approximately 270,000, includes eight towns in New Haven County: Beacon Falls, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Waterbury and Wolcott and four towns in Litchfield County: Bethlehem, Thomaston, Watertown/Oakville and Woodbury. 90 percent of Waterbury Hospital in-patients live within the primary market. Residents of the City of Waterbury account for approximately 46% of all inpatient discharges.

The secondary service area includes six towns: Morris, Oxford, Plymouth/Terryville, Seymour, Southington/Plantsville and Torrington.

Table 5.1: Waterbury Hospital Service Area Map



A. Demographics

The Hospital is located in the City of Waterbury, the fifth largest city in Connecticut. The City of Waterbury has approximately 110,000 residents, with the gender breakdown approximately an even split (53.0% female / 47.0% male). The City is also relatively young with a median age of 34.7 years.

According to the American Community Survey 2006-2010, the racial breakdown of the City of Waterbury is predominantly white/Caucasian, with a large minority of African Americans and small minority of Asians. The median household income of the Waterbury is approximately $40,000. The most recent unemployment rate of Waterbury was higher than the national trend, at 12.1%.

Table 5.2: Market Demographics

	City of Waterbury	
Male	51,341	46.7%
Female	58,600	53.3%
Total Population	109,941	100.0%
Age		
0-19 years	32,551	29.6%
20-54 years	52,039	47.3%
55-84 years	22,393	20.4%
85+ years	2,958	2.7%
Median Age	34.7	
Race		
White alone	66,179	60.2%
Black or African American alone	20,771	18.9%
Asian alone	2,051	1.9%
Two or more races	6,071	5.5%
Other	14,869	13.5%
Median Household Income	$40,254	
Mean Household Income	$52,432	
High school degree or higher	78.5%	
Unemployment rate	12.1%	
Industry of Employed over 16 Years of Age		
Agriculture, forestry, fishing and hunting and mining	84	0.2%
Construction	2,836	6.0%
Manufacturing	6,927	14.7%
Wholesale trade	982	2.1%
Retail trade	6,286	13.3%
Transportation and warehousing and utilities	2,134	4.5%
Information	1,018	2.2%
Finance and insurance, real estate, rental and leasing	2,740	5.8%
Professional, scientific, and management and administrative & waste management services	2,885	6.1%
Educational services and health care & social assistance	13,177	28.0%
Arts, entertainment, recreation, accommodation and food services	3,738	7.9%
Other services, except public administration	2,007	4.3%
Public administration	2,293	4.9%
Total	47,107	100.0%

Source: U.S. Census Bureau, 2006-2010 American Community Survey

B. Competition

Waterbury Hospital has maintained a strong market position in its Primary Service Area driven by its community reputation as a quality service provider.

Table 5.3: Competitive Landscape

		Distance from WH	Staffed Beds	Admissions	Census	Outpatient Visits	Births
1)	Waterbury Hospital	–	190	12,758	161	199,978	1,124
2)	Saint Mary's Hospital	1	181	11,198	138	233,332	1,082
3)	Bristol Hospital	10	115	NA	NA	NA	NA
4)	MidState Medical Center	13	130	8,873	110	158,405	945
5)	Griffin Hospital	16	111	7,109	87	186,418	611
6)	The Hospital of Central Connecticut	16	263	17,763	208	325,106	1,760
7)	The Charlotte Hungerford Hospital	17	105	NA	NA	NA	NA
8)	Hospital of Saint Raphael	18	406	NA	NA	NA	NA
9)	New Milford Hospital	18	62	2,251	24	114,236	261
10)	Yale-New Haven Hospital	19	959	52,302	712	413,090	4,318
11)	Veterans Affairs Connecticut Healthcare System	20	200	NA	NA	NA	NA
12)	Middlesex Hospital	21	209	12,767	150	1,370,876	1,151
13)	Danbury Hospital	23	325	18,754	247	384,655	2,164
14)	Connecticut Children's Medical Center	24	147	6,753	101	145,134	NA
15)	Hartford Hospital	24	601	37,404	576	202,847	3,792
16)	Milford Hospital	24	87	NA	NA	NA	NA
17)	Saint Francis Hospital and Medical Center	24	566	28,881	406	311,953	2,771
18)	Bridgeport Hospital	26	373	16,955	273	250,040	2,163
19)	St. Vincent's Medical Center	26	376	20,689	326	226,617	1,152

Source: American Hospital Association Guide 2011

The Hospital's primary competitors are considered:

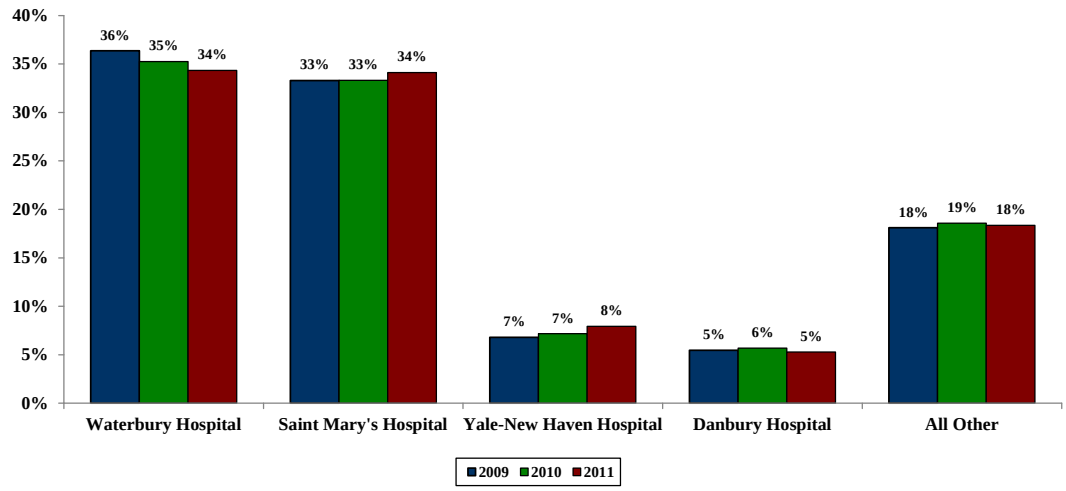
Saint Mary's Hospital – located one mile away from the Hospital, Saint Mary's is an acute care community teaching hospital that has served Greater Waterbury for more than 100 years. Licensed for 347 beds, Saint Mary's has designated Level II Trauma Center and Primary Stroke Center, and offers several acute care services including cardiac, pediatric emergency and surgical services.

Yale-New Haven Hospital – located 19 miles south of the Hospital, Yale-New Haven is a 966-bed, not-for-profit hospital serving as the primary teaching hospital for the Yale School of Medicine. The Yale-New Haven Hospital complex includes Yale-New Haven Children's Hospital, Yale-New Haven Psychiatric Hospital and Smilow Cancer Hospital at Yale-New Haven. Yale-New Haven has a combined medical staff of about 2,200 university and community physicians practicing in more than 100 specialties. The Yale-New Haven Health System consists of Yale-New Haven Hospital and its affiliates, Bridgeport Hospital and Greenwich Hospital. In September 2012, Yale-New Haven Hospital acquired the Hospital of Saint Raphael, a 511-bed community teaching hospital also in New Haven.

Danbury Hospital – located 23 miles west of the Hospital is a 371-bed regional medical center and university teaching hospital associated with Yale University School of Medicine, the University Of Connecticut School Of Medicine, and the University of Vermont. On October 1, 2010, Danbury Hospital and New Milford Hospital affiliated into "Western Connecticut Healthcare Network" and announced in early 2012 that it was exploring a partnership with Norwalk Hospital.

The Hospital has a strong market position in its PSA with 34% of the total PSA volume.

Table 5.4: Top 5 Primary Service Area Competitors



Source: Company Reports
Note: Fiscal year ends September 30

VI. Organization and Management

A. Organizational Structure and Employees

As of August 31, 2012, the Hospital had a total full time employee count of 1,265.69 FTEs. The following is the Hospital's FTEs by department:

Table 6.1: Waterbury Hospital Only Full Time Employees

(as of August 31, 2012)

Department	FTEs Assigned	Department	FTEs Assigned
Administration	5.07	Lab - Office Staff	4.48
Administrative Finance	0.63	Lab - Shift 2	8.80
Adolescent PHP & IOP	6.80	Lab - Shift 3	4.51
American Savings Foundation	0.09	Main PACU	9.58
ATT Adult Outpatient	2.81	Medical Affairs	2.00
Bed Control	3.48	Medical Library	1.60
Behavioral Health Consults	0.98	Medical Staff Office	1.01
Cardiac Diagnostic Center	17.26	Medical Unit	49.46
Cardiac Unit	21.76	Middlebury X-Ray	1.48
Cardio Pulmonary Rehab	3.03	Nuclear Medicine	2.51
Cardiology	16.26	Nursing Service Admin	10.70
Case Management	17.04	Operating Room	48.11
Center for Behav Health	57.02	OR Administration	4.91
Central Registration	30.99	Outpatient Med Therapy	5.55
Central Sterile Processing	15.23	Outpatient Testing	3.70
Children's Behav Health	3.88	P6 Med/Surg	33.49
Clinical Chemistry	10.92	Parent Trust Grant	0.63
Clinical Engineering	6.91	Partial Hospital Day Program	1.23
Crisis Center	12.97	Patient Accts/Finl Srvs	19.73
Critical Care Unit	39.51	Performance Improvement	4.71
CT Scan	9.01	Perinatology	0.80
CVU,Int Care & Tele Float Pool	1.77	Pharmacy	34.84
DBTIOP Grant	2.81	Plant Engineering	18.17
Development	1.04	Pre-Operating	15.49
Diagnostic Radiology	24.20	Primary Care	45.25
Disability Services	6.67	Private Fdn Grants	3.66
Disaster Preparedness	0.14	Psych Addiction Services	12.02
DMHAS Outpatient Grant	2.17	Psych Admin	1.26
DPH-WHAP State Approp Fd	6.91	Psych Assess & Triage	3.92
Education & Org Dev	5.01	Psych Emergency Srvs BHED	10.40
EEG	1.23	Psych O/P Services	12.27
Emergency Department	81.85	Public Affairs	2.00
Employee Benefits	0.23	Pulmonary Function	0.41
Family Birthing Center	43.49	Purchasing	6.02
FBC Admin	1.53	Radiology Special Procedures	6.24
Finance	11.54	Reed PACU	11.26
Floats	11.72	Respiratory Therapy	18.09
Gastroenterology	10.90	Respite Grant	0.38
Geriatric IOP & Outpt	4.87	Risk Management	2.00
Grants & Operations Audit	1.75	RW Yale SPNS	3.29
Health Information Mgmt	30.41	Ryan White I Grant	0.98
Human Resources	10.17	Ryan White III Grant	2.02
I/P Psych DHMAS Grant	0.12	Ryan White Part C Sup Fd	0.01
Information Services	32.32	Safety/Security	22.51
Interns & Residents	14.19	Shelter Grant	1.65
Konica, Clinical Trials	0.50	Sleep Lab	5.93
Lab - Administration	1.99	Special Care Nursery	11.66
Lab - Blood Bank	5.62	Storeroom/Receiving	5.81
Lab - Central Process	7.83	Surg/Gen Unit	51.86
Lab - Cytology	1.26	Surg/Ortho/Neuro Unit	34.91
Lab - Draw Stations	15.96	Telemetry	55.88
Lab - Hematology	4.89	Trauma Program	1.26
Lab - Histology	3.40	Ultrasound	4.98
Lab - House Calls	0.88	Yale New Hope	0.76
Lab - Microbiology	8.49	**Total FTEs**	**1,265.69**

The Hospital has a diverse medical staff with a total active medical staff of 362 physicians, comprised of physicians and dentists categorized within 30 specialty areas. Management believes there is a significant opportunity for a strategic partner to provide additional resources and enhance physician recruitment efforts.

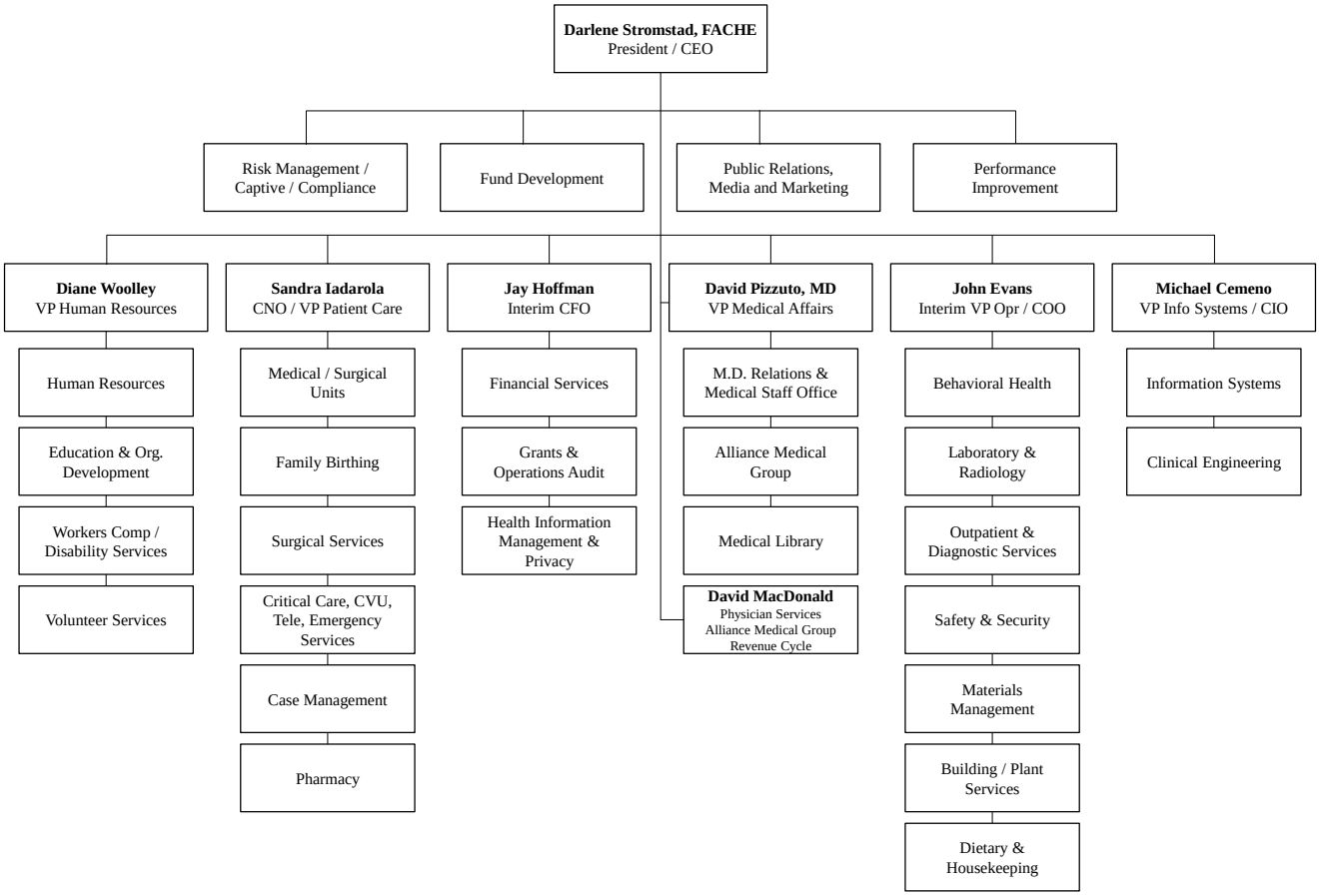
Table 6.2: Physician Staff

(as of September 10, 2012)

Clinical Services	Number of Total Attending Physicians	Average Age	Board Certified	
			Number	Percent
MEDICINE:				
General Medicine	82	45	82	100%
Cardiology	18	52	18	100%
Gastroenterology	9	58	9	100%
Oncology	5	50	5	100%
Neurology	5	47	5	100%
Pulmonary	9	52	9	100%
Dermatology	1	35	1	100%
Endocrinology	3	50	3	100%
Infectious Disease	5	40	5	100%
Nephrology	11	52	11	100%
SURGERY:				
General Surgery	12	55	12	100%
Ophthalmology	12	53	11	92%
Orthopedics	18	52	17	94%
Otolaryngology	7	55	7	100%
Urology	7	51	7	100%
Neurosurgery	5	51	5	100%
Plastic Surgery	5	56	5	100%
Oral Surgery	1	56	1	100%
Vascular Surgery	6	43	6	100%
Podiatry	16	53	16	100%
Thoracic Surgery	4	55	4	100%
PEDIATRICS	34	53	34	100%
OB/GYN	22	50	22	100%
PSYCHIATRY	11	61	11	100%
OTHER:				
Anesthesiology	16	53	16	100%
Pathology	3	47	3	100%
Radiology	9	55	9	100%
Emergency Medicine	20	43	20	100%
Rheumatology	3	51	3	100%
Physical Medicine	3	38	3	100%
TOTAL	362	50	360	99%

The table below sets forth Waterbury Hospital's corporate organization structure:

Table 6.3: Waterbury Hospital Management Organization



B. Collective Bargaining Units

Nursing, service and maintenance employees are represented by unions. Registered nurses and licensed practical nurses are represented by the Connecticut Health Care Associates, National Union of Hospital and Health Care Employees, AFSCME, AFL-CIO. The collective bargaining contracts for these unions are in effect until September 2013. The service and maintenance department is represented by the New England Health Care Employees Union, District 1199, SEIU/AFL-CIO. Its contract has expired; negotiations are underway.

Table 6.4: FTEs by Union

	FTEs
CHCA Union FTEs	352.97
1199 Union FTEs	183.38
Non-Union FTEs	729.34
Total	1,265.69

C. Executive Leadership Team Biographies

The responsibility for day-to-day operations and implementation of the Board of Trustees policies rests with Management. The Management team is led by:

Table 6.5: Waterbury Hospital Management Team

Name	Title	Age	Years with Waterbury Hospital
Darlene Stromstad, FACHE	President and CEO	56	1
David Pizzuto, MD	VP of Medical Affairs and Chief Medical Officer	57	24
Sandra Iadarola, RN	Chief Nursing Officer, VP of Patient Care	60	10
Diane Woolley	VP of Human Resources	45	5
Michael Cemeno	VP of Information Services	56	2
David MacDonald	Interim VP of Physician Services	42	1
Jay Hoffman	Interim VP of Finance	59	0
John Evans, FACHE	Interim VP of COO	57	1

Darlene Stromstad, FACHE, President and Chief Executive Officer. Ms. Stromstad joined the Hospital in July 2011 as its new President and Chief Executive Officer. Prior to coming to the Hospital, Ms. Stromstad served as President and Chief Executive Officer of Goodall Hospital and its community affiliates in Sanford, Maine for six years. Prior to becoming CEO of Goodall Hospital in 2005, she held the positions of Senior Vice President at Catholic Medical Center from 1999 to 2004, Senior Vice President at Olympus Healthcare from 1997 to 1999, and Vice President at St. Joseph Healthcare from 1988 to 1996. Ms. Stromstad holds an MBA from Rivier College and a Bachelor of Arts degree from the University of North Dakota. Ms. Stromstad is a Fellow and Member of the Board of Governors for the American College of Healthcare Executives.

David Pizzuto, MD, Vice President of Medical Affairs and Chief Medical Officer. Dr. Pizzuto became the Vice President of Medical Affairs/CMO in June 2011. A graduate of The Waterbury Hospital Internal Medicine Residency Program, he has been a member of the Attending Medical Staff for 24 years. In addition to his administrative duties, Dr. Pizzuto also continues to practice Internal Medicine full time. Dr. Pizzuto has held various leadership roles at Waterbury Hospital including Chairman of the Department of Medicine, Chief of Staff, and member of the Board of Trustees. Dr. Pizzuto holds an M.D. from New York Medical College, a Master of Science from the University of Minnesota, and a Bachelor of Science from the University of Connecticut. He is certified by the American Board of Internal Medicine.

Sandra Iadarola, RN, Chief Nursing Officer and Vice President of Patient Care. Ms. Iadarola joined the Hospital in March 2002 and served as the Administrative Director of Medical/Surgical and Critical Care Services until assuming the Chief Nursing Officer role in February 2011. Prior to coming to the Hospital, Ms. Iadarola was the Vice President of Patient Care Services at Charlotte Hungerford Hospital in Torrington, Connecticut. She had worked in progressive management positions during her 14 years there. Ms. Iadarola holds a Bachelor of Science degree in nursing from the University of Connecticut, a Masters of Business Administration with a healthcare concentration from Rensselaer Polytechnic Institute, and is a Certified Professional in Healthcare Quality.

Diane Woolley, Vice President, Human Resources. Ms. Woolley joined the Hospital in March 2007 as Administrative Director of Human Resources and has held the position of Vice President since July 2011. Prior to coming to the Hospital, Ms. Woolley served as Director of Human Resources with Smiths Interconnect/Times Microwave Systems for seven years and with United Technologies Corporation for

eight years. Ms. Woolley holds an MBA, a Master's of Science in Human Resource Management both from Rensselaer at Hartford, and a Bachelor of Science degree from Post University.

Michael Cemeno, Vice President, Chief Information Officer. Mr. Cemeno joined Waterbury Hospital in March 2011 as Chief Information Officer. Prior to coming to the Hospital, Mr. Cemeno served as Associate Chief Information Officer at Yale New Haven Health System for nine years. Prior to becoming Associate CIO, he held the position of Vice President of IT and CIO at Greater Hudson Valley Health System for five years. Mr. Cemeno holds a Bachelor Degree in Business Administration from Temple University in Philadelphia.

David MacDonald, Interim Vice President, Physician Services. Mr. MacDonald joined Waterbury Hospital in May 2011 and is Vice President of Physician Services for Waterbury Hospital and Alliance Medical Group. Prior to working with the Hospital, Mr. MacDonald worked at a major academic medical center in Boston. Founder of Aegle Advisors, Mr. MacDonald spent nearly two decades developing leadership skills in a multitude of areas including healthcare delivery strategy, finance, and operations in a variety of for-profit and not-for-profit healthcare settings. Mr. MacDonald spent several years as a healthcare consultant and attorney in the Commonwealth of Massachusetts. He was also Vice President of Finance, CFO, and In-House Counsel for a healthcare services organization in Southeastern United States. Mr. MacDonald holds a Bachelor of Science degree in Accounting from West Virginia University, a Juris Doctorate from Roger Williams University in Rhode Island, and an Executive MBA from Emory University in Atlanta.

Jay Hoffman, Interim Chief Financial Officer. Mr. Hoffman joined the Hospital in August 2012 as its Interim CFO. He has been operating a transitional firm, JH Enterprises, since 2003, which provides transition management services to hospitals, health systems, and multi-specialty physician group practices. Prior to developing JH Enterprises, he served as Vice President of Finance for Clarian Health Partners (known as IU Health), in Indianapolis; Vice President of Corporate Finance for Parkview Health and CFO of its flagship hospital Parkview Hospital, Fort Wayne; Chief Financial Officer of St. Joseph Hospital, Lancaster, PA; Vice President of Finance, Summa Health System, Akron, OH; and Hospital Management Professionals, Inc., Naperville. Mr. Hoffman holds an MBA from LaSalle University, Philadelphia and a Bachelor of Science degree from The Pennsylvania State University. He is a Certified Public Accountant and a Fellow in HFMA.

John Evans, FACHE, Interim Chief Operating Officer. Mr. Evans joined Waterbury Hospital in April 2011 as the Interim COO. Prior to Waterbury he was President of Strategic Alliance Advisors (s2a) for six years. Prior to s2a he was Chief Operating Officer at Fletcher Allen Healthcare, the academic medical center for Vermont. Prior to Fletcher Allen he served with St. Vincent's Health Services (SVHS) in Bridgeport, CT, first as EVP/COO at St. Joseph Medical Center in Stamford, and then as SVP, Operations at St. Vincent's Medical Center in Bridgeport, CT, the acute care hub for SVHS. Prior to SVHS Mr. Evans was President/CEO of NovaMed for five years, a for-profit diversified health services and technology company. During the first ten years of his career, Mr. Evans served in various healthcare executive positions in the US Army. Mr. Evans holds an MHA from Baylor University and a BA from the University of Vermont.

VII. Financial Overview

A. GWHN Historical Financial Statements

Table 7.1: GWHN and Subsidiaries Historical Income Statement

($ in millions)

	For the Fiscal Years Ended September 30,				
	2007	**2008**	**2009**	**2010**	**2011**
Revenues:					
Net revenues from services to patients	$239.2	$240.0	$258.1	$259.8	$270.7
Investment related income	6.1	1.3	2.7	1.3	1.5
Other operating revenues	4.7	5.0	3.5	6.8	8.0
Service, sales and rental income	3.3	9.2	9.2	3.6	1.6
Unrestricted gifts and bequests	0.2	0.2	0.5	0.2	0.3
Net assets released from restrictions	4.4	4.7	5.1	5.4	5.9
Total Revenue	**$257.9**	**$260.4**	**$279.1**	**$277.1**	**$288.1**
% Growth	*5.0%*	*0.9%*	*7.2%*	*(0.7%)*	*4.0%*
Expenses:					
Salaries, wages and benefits	148.3	154.4	152.1	158.9	174.3
Supplies, utilities and other	78.5	89.3	90.6	90.9	96.8
Bad debt expense	21.9	17.9	14.4	15.7	11.7
Depreciation	11.0	10.5	9.9	9.8	9.5
Operations improvement	-	-	12.9	2.7	0.3
Interest and Amortization	1.9	1.7	1.6	1.9	1.3
Investment fees and bank charges	0.2	0.2	-	-	-
Total Expenses	$261.7	$274.0	$281.6	$279.9	$293.9
Gain (loss) from operations	**($3.8)**	**($13.6)**	**($2.5)**	**($2.9)**	**($5.8)**
Minority interest	(1.4)	(1.1)	(1.3)	(1.0)	(1.1)
Other nonoperating expenses	0.1	(3.1)	0.5	1.4	(2.9)
Total other income (expense)	($1.3)	($4.2)	($0.8)	$0.4	($4.0)
Excess of revenue over expenses	**($5.1)**	**($17.8)**	**($3.3)**	**($2.5)**	**($9.8)**
EBIDA[(1)]	**$9.2**	**($1.2)**	**$21.9**	**$11.6**	**$5.3**
Margin	*3.6%*	*(0.5%)*	*7.9%*	*4.2%*	*1.8%*
Operating Income[(1)]	**($1.8)**	**($11.7)**	**$12.0**	**$1.7**	**($4.2)**
Margin	*(0.7%)*	*(4.5%)*	*4.3%*	*0.6%*	*(1.5%)*

(1) Excludes one-time fees including operations improvement expenses and investment fees and bank charges

Table 7.2: GWHN and Subsidiaries Historical Balance Sheet

($ in millions)

	As of September 30,				
	2007	**2008**	**2009**	**2010**	**2011**
Current Assets					
Cash and cash equivalents	$8.6	$14.5	$19.3	$22.3	$16.7
Short-term investments	0.9	0.9	0.8	0.9	1.0
Accounts receivable, net	36.0	36.9	33.0	32.6	37.0
Other receivables	1.4	0.8	1.1	1.7	2.5
Inventory	0.5	0.6	0.6	0.8	0.9
Prepaid expenses and other	1.5	1.8	1.4	1.4	1.8
Due from third-party reimbursement agencies	-	0.6	-	-	2.6
Due from affiliates	1.1	2.6	1.5	0.2	0.2
Assets whose use is limited and required for current liabilities	3.1	2.7	0.6	0.6	-
Other current assets	0.2	0.3	0.1	-	-
Total Current Assets	$53.4	$61.6	$58.5	$60.5	$62.6
Funds held by trustee	$9.8	$4.8	$0.0	-	-
Funds held in escrow by agreement with CHEFA and trustee	2.6	2.6	2.6	2.6	4.0
Assets whose use is limited and required for current liabilities	(3.1)	(2.7)	(0.6)	(0.6)	-
Funds held in trust by others	47.2	38.5	37.9	39.6	37.3
Long-term investments	48.3	33.2	30.2	32.3	29.0
Board-designated endowment funds	-	-	2.7	2.8	2.6
Other investments	0.2	0.1	0.2	0.3	0.1
Prepaid pension and other investments	1.8	-	-	-	-
Loans and other receivables	1.8	1.1	0.9	0.4	0.2
Accrued interest and dividends receivable	0.1	0.1	0.1	0.1	0.0
Goodwill	-	-	-	-	1.8
CHEFA obligations issue expense	0.8	0.7	0.7	0.7	0.4
Property, plant and equipment, net	63.6	57.4	50.1	45.8	52.0
Total Assets	**$226.5**	**$197.5**	**$183.3**	**$184.4**	**$190.1**
Current Liabilities					
Accounts payable and accrued expenses	$21.5	$30.9	$25.1	$28.7	$38.8
Due to third-party reimbursement agencies	2.5	-	1.2	0.4	-
Current portion of CHEFA obligations	0.8	0.8	0.9	0.9	0.5
Current portion of notes payable	5.9	5.0	0.4	0.5	0.6
Due to affiliates	-	0.4	-	0.0	0.0
Total Current Liabilities	$30.7	$37.1	$27.6	$30.6	$39.9
Other noncurrent liabilities	$8.9	$7.8	$14.4	$14.7	$19.8
CHEFA obligations	22.2	21.4	20.5	19.7	26.6
Notes payable	1.8	0.6	0.6	0.7	1.5
Minority interest	2.5	2.4	2.5	2.9	3.2
Total Liabilities	$66.1	$69.3	$65.6	$68.6	$91.1
Net Assets					
Unrestricted	$96.8	$76.2	$69.3	$65.2	$52.4
Temporarily restricted	13.5	10.7	7.8	8.3	6.5
Permanently restricted	50.0	41.3	40.7	42.4	40.1
Total Net Assets	$160.3	$128.2	$117.7	$115.9	$99.0
Total Liabilities and Net Assets	**$226.5**	**$197.5**	**$183.3**	**$184.4**	**$190.1**

B. Waterbury Hospital Historical Financial Statements

Table 7.3: Waterbury Hospital and Subsidiaries Historical Income Statement

($ in millions)

	For the Fiscal Years Ended September 30,					LTM
	2007	2008	2009	2010	2011	July 2012
Revenues:						
Net revenues from services to patients	$234.7	$235.3	$253.5	$254.8	$265.9	$271.8
Other operating revenues	4.6	5.2	3.3	6.6	7.9	7.4
Net assets released from restrictions	4.4	4.7	5.1	5.4	5.9	5.9
Total Revenue	**$243.8**	**$245.2**	**$261.9**	**$266.8**	**$279.7**	**$285.0**
% Growth	*5.0%*	*0.6%*	*6.8%*	*1.9%*	*4.8%*	
Expenses:						
Salaries and benefits	140.0	144.0	142.8	153.2	169.7	161.5
Supplies and Other	74.7	80.9	82.0	87.6	95.0	103.2
Bad debts	21.9	17.9	14.4	15.7	11.7	11.7
Depreciation	10.6	10.1	9.6	9.6	9.3	9.7
Operations Improvement	-	-	12.9	2.7	0.3	-
Interest and Amortization	1.7	1.6	1.5	1.8	1.2	1.2
Total Expenses	$248.9	$254.5	$263.2	$270.6	$287.2	$287.3
Gain (loss) from operations	**($5.1)**	**($9.2)**	**($1.3)**	**($3.8)**	**($7.5)**	**($2.2)**
Minority interest	(1.4)	(1.1)	(1.3)	(1.0)	(1.1)	(0.9)
Unrestricted gift and bequests	0.1	0.1	0.4	0.2	0.3	0.3
Investment income	1.9	1.9	1.6	1.6	1.7	1.7
Realized (losses) gains on sales of investments	0.1	(0.0)	(0.0)	0.0	-	-
Other nonoperating expenses	0.1	(0.1)	1.0	(0.8)	(1.8)	(1.8)
Total other income (expense)	$0.8	$0.8	$1.8	($0.0)	($1.0)	($0.7)
Excess of revenue over expenses	**($4.3)**	**($8.5)**	**$0.5**	**($3.8)**	**($8.5)**	**($2.9)**
EBIDA[(1)]	**$7.2**	**$2.5**	**$22.7**	**$10.3**	**$3.3**	**$8.7**
Margin	*2.9%*	*1.0%*	*8.7%*	*3.9%*	*1.2%*	*3.0%*
Operating Income[(1)]	**($3.4)**	**($7.6)**	**$13.1**	**$0.7**	**($6.0)**	**($1.0)**
Margin	*(1.4%)*	*(3.1%)*	*5.0%*	*0.3%*	*(2.1%)*	*(0.3%)*

(1) Excludes one-time fees including operations improvement expenses

Table 7.4: Waterbury Hospital and Subsidiaries Balance Sheet as of July 31, 2012

($ in millions)

ASSETS		**LIABILITIES & NET ASSETS**	
Cash & Cash Equivalents	$17.9	Accounts Payable	$13.6
Net Accounts Receivable	40.9	Accrued Expenses	14.0
Due from Affiliates	(7.1)	Accrued Pension	10.3
Other Investments	4.4	Long-Term Debt	29.3
Net Property, Plant & Equipment	47.6	Due to Third-Party Payors	(2.2)
Other Assets	7.3	Other Liabilities	13.4
		Minority Interest in Net Assets of Affiliates	3.0
		Net Assets	29.5
Total Assets	**$110.9**	**Total Liabilities & Shareholders' Equity**	**$110.9**

Table 7.5: Waterbury Hospital and Subsidiaries Historical Balance Sheet

($ in millions)

	As of September 30,				
	2007	**2008**	**2009**	**2010**	**2011**
Current Assets					
Cash and cash equivalents	$8.0	$13.6	$18.6	$21.4	$15.4
Short-term investments	0.3	0.3	0.4	0.4	0.4
Accounts receivable, net	35.4	35.7	32.4	31.8	36.4
Other receivables	1.4	0.8	1.1	1.7	2.5
Inventory	0.5	0.6	0.6	0.8	0.9
Prepaid expenses and other	1.5	1.8	1.4	1.4	1.7
Due from third-party reimbursement agencies	-	0.8	-	-	2.9
Due from affiliates	4.0	-	0.9	-	3.8
Assets whose use is limited and required for current liabilities	3.1	2.7	0.6	0.6	-
Total Current Assets	$54.1	$56.4	$55.8	$58.1	$64.0
Funds held by trustee	$9.8	$4.8	$0.0	-	-
Funds held in escrow by agreement with CHEFA and trustee	2.5	2.6	2.6	2.6	4.0
Assets whose use is limited and required for current liabilities	(3.1)	(2.7)	(0.6)	(0.6)	-
Other Long Term Assets					
Funds held in trust by others	47.2	38.5	37.9	39.6	37.3
Long-term investments	15.4	12.7	9.6	10.1	8.8
Board-designated endowment funds	-	-	2.7	2.8	2.6
Other receivables	1.5	0.9	0.7	0.1	0.0
Due from affiliates	-	-	4.9	5.7	-
Prepaid pension and other investments	1.8	-	-	-	-
Goodwill	-	-	-	-	1.8
CHEFA obligations issue expense	0.7	0.6	0.6	0.6	0.4
Property, plant and equipment, net	59.4	53.4	45.8	43.3	49.6
Total Assets	**$189.4**	**$167.2**	**$160.0**	**$162.3**	**$168.5**
Current Liabilities					
Accounts payable and accrued expenses	$11.7	$20.3	$15.8	$19.0	$27.3
Accrued salaries	8.6	9.2	8.2	9.2	10.1
Due to third-party reimbursement agencies	2.4	-	1.0	0.2	-
Current portion of CHEFA obligations	0.8	0.8	0.8	0.9	0.4
Current portion of notes payable	5.1	1.2	0.3	0.5	0.6
Due to affiliates	-	0.7	-	0.2	-
Total Current Liabilities	$28.5	$32.2	$26.2	$29.9	$38.4
Other noncurrent liabilities	$8.9	$7.8	$14.4	$14.7	$19.8
CHEFA obligations	20.5	19.8	19.0	18.1	25.2
Notes payable	1.7	0.5	0.3	0.7	1.5
Minority interest	2.5	2.4	2.5	2.9	3.2
Total Liabilities	$62.2	$62.7	$62.3	$66.4	$88.1
Net Assets					
Unrestricted	$63.7	$52.4	$49.3	$45.2	$33.7
Temporarily restricted	13.5	10.7	7.8	8.3	6.5
Permanently restricted	50.0	41.3	40.7	42.4	40.1
Total Net Assets	$127.2	$104.5	$97.7	$95.9	$80.3
Total Liabilities and Net Assets	**$189.4**	**$167.2**	**$160.0**	**$162.3**	**$168.5**

XIII. Appendices

Appendix A – Response Matrix

Transaction Element	Description
1. Form of Transaction	a) Please describe the structure of the proposed transaction and resulting relationship with the surviving GWHN organization.
2. Objectives Alignment	Please describe how you envision achieving GWHN's Objectives: a) Ensure Waterbury Hospital remains a viable health care entity, providing the highest safety and quality health care services to the Greater Waterbury community for the long-term; b) Provide sufficient capital to meet deferred, current and future capital needs for the Waterbury Hospital physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology; c) Continue a meaningful, local governance presence at Waterbury Hospital that represents both physicians and the Greater Waterbury community; d) Develop and implement an ambulatory service strategy to best position the Company for successful transition in changing health care delivery methods; e) Develop and implement regional tertiary care relationships for the betterment of health care delivery to the community; f) Deploy repeatable and scalable tools and clinical care services to continually improve the health of the community; g) Enhance the Hospital's medical staff by attracting and retaining physicians through access to available capital partner funds to support such growth; h) Maintain high satisfaction scores by patients, physicians, employees and volunteers; and i) Continue charitable care delivery and funding.
3. Ownership, Governance and Management	a) Describe how GWHN will be organized in relation to your organization. b) Describe the proposed governance structure and the ongoing role, if any, of GWHN's current Board of Directors. c) Describe the proposed management organizational structure for GWHN.
4. Transaction Value	If you are proposing an asset purchase, please describe how GWHN will be valued, including the methodology and calculation of any adjustments to the proposed consideration.
5. Maintenance of Clinical Services	a) Describe your commitment to maintaining existing clinical services. b) Describe any new services you anticipate implementing over the next five years. c) Describe which, if any, clinical services may not be maintained at GWHN and the Hospital. d) Indicate the minimum time horizon for maintaining existing services.
6. Excluded Activities and Operations	a) Describe any GWHN activities and operations that are expected to be excluded from a transaction. b) Describe how the surviving GHWN organization (if any) could support the ongoing activities of the acquired operations after the transaction.

Transaction Element	Description
7. Charity Care	Describe your existing charity and indigent care policies and any potential changes to GWHN policies you foresee.
8. Ethical and Religious Directives	Describe any ethical or religious directives of your organization, if any, which would impact the future operations of GWHN.
9. Employee Relationships	a) Describe your commitment to GWHN employees, anticipated layoffs, and type of severance package that may be offered to any affected employees. b) Describe any anticipated employee benefit changes.
10. Capital Expenditure Commitments	Describe your expectations and commitment to capital investments over the next five years to improve GWHN facilities and expand programs and services.
11. No Sale	Describe your commitment to retaining ownership of the GWHN operations acquired.
12. Right of First Refusal/Repurchase Rights	Describe any terms and conditions under which the surviving GWHN organization (if any) could reacquire interests transferred in a transaction.
13. Financial and Operating Information	a) Provide a copy of your most recent audited financial statements. b) Describe how you propose to finance the transaction and any proposed ongoing financial commitments to GWHN. c) Provide an overview of your existing operations, including, but not limited to, the following: (i) Number and location of facilities owned and operated (ii) Number of beds owned and operated (iii) Key operating statistics (iv) Key quality indicators
14. Due Diligence	a) Describe your due diligence process. b) Provide a list of due diligence items you would like to receive in Phase II if you are selected to continue in the process.
15. Process and Approvals	Indicate the level at which your response has been approved within your organization and what approvals will be required to sign a Definitive Agreement and to close the transaction.
16. Other	Please describe any other factors that GWHN should consider in evaluating your proposal.

Appendix B – 2011 GWHN Audited Financials

See Separate PDF© File

Appendix C – 2011 Hospital Audited Financials

See Separate PDF© File

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CAIN BROTHERS & COMPANY, LLC

EXHIBIT Q6-1

CONFLICT OF INTEREST/FINANCIAL DISCLOSURES - GWHN

Conflict of Interest/Financial Disclosure Form

The Application of the Greater Waterbury Health Network, Inc. and its Affiliates ("GWHN") and Prospect Medical Holdings, Inc. ("Prospect") to the Connecticut Attorney General and the Connecticut Department of Public Health requests permission to sell substantially all of the assets of GWHN to Prospect and operate the facility known as The Waterbury Hospital as a subsidiary or affiliate of Prospect (the "New Hospital").

---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Darlene Stromstad

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO ____ YES. If YES, please provide details.

(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

9/15/15
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
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Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
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Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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Prospect Health Services NJ, Inc.	Delaware/Corporation

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Nix SPE, LLC	Texas/LLC
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New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
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Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

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1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: MICHAEL CARMENO

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

X NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

X NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

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X NO _____ YES. If YES, please provide details.

_____

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_____

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_____

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X NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

X NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

_____ 9/10/2015

Signature Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
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AMVI/Prospect Medical Group	California/Joint Venture
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Prospect NJ, Inc.	Delaware/Corporation
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(a) Please provide the following information:

Print Name: David J. Pizzuto, MD

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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Chairman Board of Managers - Prospect Provider Group CT-Waterbury LLC. No income to date

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO ____ YES. If YES, please provide details.

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(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

9-16-15
Date

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(a) Please provide the following information:

Print Name: MARK HOLTZ

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

X NO ____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

X NO ____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

X NO ____ YES. If YES, please provide details.

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

X NO ____ YES. If YES, please provide details.

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

X NO ____ YES. If YES, please provide details.

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

X NO ____ YES. If YES, please provide details.

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Mark Hoz
Signature

September 16, 2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

Conflict of Interest/Financial Disclosure Form

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: JAMES J. MOYNAN

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

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(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

James J. Moyle
Signature

9/17/2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
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Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
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PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
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New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
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Prospect East Holdings, Inc.	Delaware/Corporation
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Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
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Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

Conflict of Interest/Financial Disclosure Form

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: John Camus

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

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_____

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(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

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(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 9-16-15

Signature Date

Exhibit A

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Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
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Prospect NJ, Inc.	Delaware/Corporation
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Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
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1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Sandra A. Iadarola

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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X NO ____ YES. If YES, please provide details.

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(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Sandra A Sadowski
Signature

9/16/15
Date

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Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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(a) Please provide the following information:

Print Name: Richard P Knopp

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

____ NO ____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

____ NO ____ YES. If YES, please provide details.

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(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

____ NO ____ YES. If YES, please provide details.

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4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

____ NO ____ YES. If YES, please provide details.

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____ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Richard P Hupp
Signature

9/16/2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
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Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
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New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
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Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
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Alta Metro Hospital, Inc.	California/Corporation
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1. **Instructions:**

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(a) Please provide the following information:

Print Name: Patricia Gentil

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

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(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

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__X__ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

__X__ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Patricia Scott
Signature

9-16-15
Date

Exhibit A

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Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
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Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
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---

1. **Instructions:**

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(a) Please provide the following information:

Print Name: Carl Conti Tadini

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

_____ 10-2-2015

Signature Date

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Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
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(a) Please provide the following information:

Print Name: William J. Pizzuto

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Signature

09/15/15
Date

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(a) Please provide the following information:

Print Name: Carl Shuster, MD

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

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3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

__X__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

__X__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

__X__ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

__X__ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

__X__ NO _____ YES. If YES, please provide details.

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(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

__X__ NO _____ YES. If YES, please provide details.

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_X_ NO ____ YES. If YES, please provide details.

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_X_ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Paul Shapiro MD
Signature

9/14/15
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
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Prospect NJ, Inc.	Delaware/Corporation
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Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
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PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
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Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Patricia A. McKinley

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

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(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

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(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Patricia A. McKinley
Signature

September 15, 2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
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Prospect Professional Care Medical Group, Inc.	California/Corporation
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StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
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Nix SPE, LLC	Texas/LLC
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Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
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Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: FRANK SHERED

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 9/15/2015

Signature Date

Exhibit A

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Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Newport Hospital, Inc.	California/Corporation
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ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
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Prospect EOGH, Inc.	New Jersey/Corporation
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---

1. **Instructions:**

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(a) Please provide the following information:

Print Name: Henry Borkowski M.D

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature _____ Date 9/30/15

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(a) Please provide the following information:

Print Name: Ronald D'Andrea, M.D.

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

Sep. 30. 2015 12:58PM RONALD DANDREA MD No. 2438 P. 2

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

__✓__ NO ____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

__✓__ NO ____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

__✓__ NO ____ YES. If YES, please provide details.

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

__✓__ NO ____ YES. If YES, please provide details.

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

__✓__ NO ____ YES. If YES, please provide details.

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

__✓__ NO ____ YES. If YES, please provide details.

Sep. 30. 2015 12:58PM RONALD DANDREA MD No. 2438 P. 3

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

____ NO ____ YES. If YES, please provide details.

(ii) Leased assets to or leased assets from a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

(iii) Been indebted to or loaned money to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

9.30.15
Date

Sep. 30. 2015 12:58PM RONALD DANDREA MD No. 2438 P. 4

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
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Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
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APAC Medical Group, Inc.	California/Corporation
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1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Neil F. Petersen

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO ____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

27 Sept 15
Date

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ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
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Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: JOHN A. KELLY, JR

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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_____

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X NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

20 September 2015
Date

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(a) Please provide the following information:

Print Name: James H. Gatling

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I hereby attest that the following information is true and accurate to the best of my knowledge.

James H. Gatti
Signature

9-14-15
Date

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(a) Please provide the following information:

Print Name: John Michaels

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

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_____

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✓ NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 10-2-15

Signature Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type o Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
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Prospect EOGH, Inc.	New Jersey/Corporation
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Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
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Prospect CharterCARE, LLC	Rhode Island /LLC
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Conflict of Interest/Financial Disclosure Form

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1. **Instructions:**

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(a) Please provide the following information:

Print Name: SuNOAe Black

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_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

10/12/15
Date

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Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
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Prospect Provider Group NJ, LLC	Delaware/LLC
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Prospect East Hospital Advisory Services, LLC	Delaware/LLC
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
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Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: James Cain

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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3. **Financial Interests**

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_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

_____ NO X YES. If you answered YES, please note the name of the entity and income generated from the entity.

We provided a fairness opinion to Prospect Medical that was unrelated to GWHV. Total fees & expenses were $125,000

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

_____ NO X YES. If YES, please provide details.

Cain Brothers is advisor to GWHV

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

X NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

X NO _____ YES. If YES, please provide details.

_____

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(ii) Leased assets to or leased assets from a Prospect Entity.

__X__ NO _____ YES. If YES, please provide details.

(iii) Been indebted to or loaned money to a Prospect Entity.

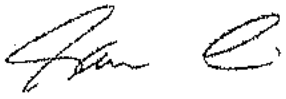
__X__ NO _____ YES. If YES, please provide details.

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

_____ NO, __X__ YES. If YES, please provide details.

See Section 3(b) above.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

October 19, 2015

Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
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(a) Please provide the following information:

Print Name: Chris McDonough

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Cain Brothers is advisor to GWHN

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Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

Conflict of Interest/Financial Disclosure Form

The Application of the Greater Waterbury Health Network, Inc. and its Affiliates ("GWHN") and Prospect Medical Holdings, Inc. ("Prospect") to the Connecticut Attorney General and the Connecticut Department of Public Health requests permission to sell substantially all of the assets of GWHN to Prospect and operate the facility known as The Waterbury Hospital as a subsidiary or affiliate of Prospect (the "New Hospital").

---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Patrick J. Simers

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

_X_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

_X_ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

_X_ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

_X_ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

_X_ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

_X_ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_X_ NO ____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Patel J Senior
Signature

9-28-2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
Prospect Hospital Holdings, LLC	Texas/LLC
Nix Hospitals System, LLC	Texas/LLC
Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

Conflict of Interest/Financial Disclosure Form

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Ann H. Zucker

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

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(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

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✓ NO _____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Anne N. Fonbuena
Signature

5.22.15
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
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Nix Hospitals System, LLC	Texas/LLC
Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

EXHIBIT 6-2

CONFLICT OF INTEREST/FINANCIAL DISCLOSURE FORMS (PMH)

PMH CONFLICT OF INTEREST DISCLOSURES
GWHN TRANSACTION

Name	**Affiliation**
Alyse Wagner	Director, BOD
John Baumer	Director, BOD
Michael Solomon	Director, BOD
Sam Lee	Chairman, BOD; CEO, PMH
Dr. Jeereddi Prasad	Director, BOD, President, ProMed
Dr. Mitchell Lew	President, PMH
Steve Aleman	CFO, PMH
Ellen Shin	General Counsel & Secretary, PMH
David Topper	President, Alta
Jonathan Spees	SVP, M&A, PMH
Von Crockett	SVP, Corporate Development, PMH
Steve O'Dell	SVP, CRC, PMH
Thomas Reardon	President, Prospect East
Gary Herschman	Epstein, Becker
Michele Volpe	Bernstein, Volpe
Jay Krupin	Baker Hostetler
Elizabeth Dold	Groom Law Group
Alan Weiss	Lockton
Jim Tinyo	Keenan
Arthur Rains-McNally	Milliman
Chris Kujawa	Ernst & Young LLP
Rosemary Free	Ernst & Young LLP

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Alyse Wagner

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

_X_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

_X_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_X_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_X_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_X_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

_X_ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Alyse Wagner
Signature

9/18/15
Date

Alyse Wagner
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: JOHN BAUMER

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

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X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

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(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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_____

[*Continues on the Following Page*]

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(iii) Been indebted to or loaned money to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

JBaumer
Signature

10-8-2015
Date

JOHN BAUMER
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michael Solomon

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

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[*Continues on the Following Page*]

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✓ NO _____ YES. If YES, please provide details. _____

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✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/18/15
Date

Michael Solomon
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: SAM LEE

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

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[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9-21-15
Date

SAM LEE
Printed Name

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Please provide the following information:

Print Name: K PRASAD JEGADDI

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_____ NO _____ YES. If YES, please provide details. _____

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature Date

PRASAD JEEREDDI

Printed Name

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Please provide the following information:

Print Name: Mitchell Lew

(b) Please complete and return the Disclosure Form no later than September 25, 2015 to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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_✓_ NO _____YES. If YES, please provide details. _____

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(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_✓_ NO _____YES. If YES, please provide details. _____

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(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Mitchell Lew 9/27/15

Signature Date

Mitchell Lew

Printed Name

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Please provide the following information:

Print Name: STEVE ALEMAN

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

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(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

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__X__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/18/15
Date

STEVE ALEMAN
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Ellen Shin

(b) Please complete and return the Disclosure Form no later than September 25, 2015 to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/7/15
Date

Ellen Shin
Printed Name

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Please provide the following information:

Print Name: DAVID TOPPER

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ _____

Signature Date

DAVID TOPPER

Printed Name

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Please provide the following information:

Print Name: JONATHAN SPEES

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____ YES. If YES, please provide details. NOTE: TRANSACTIONS ARE MY PRINCIPAL JOB RESPONSIBILITY & THE PROPOSED TRANSACTION WILL BE CONSIDERED IN MY OVERALL PERFORMANCE EVALUATION & BONUS CALCULATION.

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/9/15
Date

JONATHAN SLOSS
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Tom Crockett

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

_____ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

_____ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

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_____ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

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_____

[*Continues on the Following Page*]

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✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9-17-15

Donna L. Crockett

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: STEPHEN T. O'DELL

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

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_____

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X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

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_____

[*Continues on the Following Page*]

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__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/9/15
Date

STEPHEN T. O'DELL
Printed Name

Conflict of Interest / *Financial Disclosure Form*

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Thomas M. Rogers

(b) **Please complete and return the Disclosure Form no later than September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

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3. ***Financial Interests:***

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

_X_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

_X_ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

☆ _____ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_X_ NO _____ YES. If YES, please provide details. _____

_____

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(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_X_ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

_X_ NO _____ YES. If YES, please provide details. _____

_____

☆ TRANSACTIONS ARE A SUBSTANTIAL PART OF MY JOB RESPONSIBILITIES AND THE PROPOSED TRANSACTION WILL BE CONSIDERED IN MY OVERALL PERFORMANCE AND BONUS CALCULATION.

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

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X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/8/15
Date

THOMAS M. REARDON
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

   (a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

   Please provide the following information:

   Print Name: Gary Herschman

   (b) Please complete and return the Disclosure Form no later than September 25, 2015 to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

   (c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

   (a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Gary Hersch 9/24/2015

Signature Date

Gary Herschman

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions**:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michele Volpe

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

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(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

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_____

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_____

[*Continues on the Following Page*]

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_____ NO _____ YES. If YES, please provide details. _____

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_____ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9/18/15

Michele Volpe
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Jay P. Krupin on behalf of Baker & Hostetler LLP

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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_____

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_____

[*Continues on the Following Page*]

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__X__ NO _____YES. If YES, please provide details. _____

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__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

Sept. 21, 2015
Date

Jay P. Krupin
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Elizabeth T. Dold

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

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[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/17/2015
Date

Elizabeth T. Dold
Printed Name

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Please provide the following information:

Print Name: ALAN WEISS

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/17/2015
Date

ALAN M WEISS
Printed Name

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Please provide the following information:

Print Name: James D. Tinyo

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

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__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

James D Tinyo
Signature

9-17-15
Date

James D. Tinyo
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Arthur Rains-McNally

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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_____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ 10/15/15

Signature Date

Arthur Rains-McNally

Printed Name

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Please provide the following information:

Print Name: CHRIS KUJAWA

(b) Please complete and return the Disclosure Form no later than September 25, 2015 to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/12/2015
Date

CHRIS KUJAWA
Printed Name

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Please provide the following information:

Print Name: ____Rosemary Free Ernst & Young LLP_____

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(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X____ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

____ Digitally signed by rosemary parkerofree.com DN: cn=rosemary parkerofree.com Date: 2015.10.08 15:24:16 -04'00' ____ _____10.8.15_____

Signature Date

__Rosemary P Free_____

Printed Name

EXHIBIT 6-3

CODE OF BUSINESS CONDUCT (PMH)

Code of Business Conduct Ethical Business Practice

As approved by the Board of Directors on September 10, 2013

A Message to Directors and Employees:

As Directors and employees of Prospect Medical Holdings, Inc and its subsidiaries (referred to in the following pages as "Company"), we are responsible for conducting the business affairs of the Company in accordance with applicable laws, in an honest manner, and with the highest professional and ethical standards.

To make certain that we understand what is expected of us, the Company and its Board of Directors have adopted the following policies.

This Code of Business Conduct / Ethical Business Practice and the incorporated corporate policies (collectively, "Code") contain commonsense rules of conduct. We ask that you read the Code carefully and completely, because it is essential that you fully comply with these policies in the future. If you have any questions, talk them over with your manager or another member of management. Alternatively, feel free to contact the Human Resources or Legal Departments.

Please sign the acknowledgment page confirming that you have received the Code, understand it represents mandatory policies of the Company and agree to abide by it. Return the signed copy to the Human Resources Department where it will be placed in your personnel file and keep the Code for future reference.

Thank you for your attention to this important matter.

Sincerely,

Samuel S. Lee
Chairman and Chief Executive Officer

Code of Business Conduct / Ethical Business Practice

Directors and employees of the Company, its subsidiaries and affiliated companies, are to conduct their business affairs in accordance with the highest ethical standards. Policies are to be applied in good faith with reasonable business judgment to enable the Company to achieve its operating and financial goals within the framework of the law. Directors and employees shall not conduct themselves in a manner that is directly or indirectly detrimental to the best interests of the Company or in a manner which would bring financial or any other gain to any Director or employee at the expense of the Company. Ethical as well as legal obligations will be fulfilled openly, promptly, and in a manner that will reflect positively on the Company's name.

Agreements, whether written or verbal, will be honored. No bribes, bonuses, kickbacks, lavish entertainment, or gifts will be exchanged for special position, price, or privilege. It is Company policy that contracts are reviewed by legal counsel. By contract, we mean each agreement, memorandum of understanding, or other document or arrangement that could reasonably be expected to impose an obligation. Please bear in mind that your conduct and/or your conversations may have, under certain circumstances, the unintended effect of creating an obligation which the Company cannot meet.

The Company requires Directors and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. Directors and employees must practice honesty and integrity in every aspect of dealing with other Directors and employees, the public, the business community, stockholders, customers, members and government authorities.

Directors and employees will maintain the confidentiality of the Company's sensitive or proprietary information and will not use such information for their personal benefit or the benefit of another person or entity. Directors and employees shall refrain, both during and after their employment, from publishing any oral or written statements about the Company or any of its Directors or employees that are slanderous, libelous or defamatory. Statements disclosing private or confidential information about their business affairs or constituting an intrusion into their private lives should be avoided.

Directors and employees will comply with the stock ownership requirements set forth by the Board of Directors, which may relate to the ownership of stock in the Company's parent company or other affiliates.

The Company prohibits unlawful discrimination against Directors and employees, stockholders, members, customers or suppliers on account of race, color, religion, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition, or any other consideration made unlawful by applicable laws. All persons shall be treated with dignity and respect and they shall not be interfered with in the conduct of their duties and responsibilities.

Directors and employees should not be misguided by any sense of loyalty to the Company or a desire for profitability that might cause them to disobey any applicable law or Company policy. Illegal behavior on the part of any Director or employee in the performance of Company duties will not be condoned or tolerated.

The Company is committed to evaluating the effectiveness of the Code through various efforts on an ongoing basis. Adherence to and support of the Code is a condition of employment. Violation may result in disciplinary action, which may include termination.

The Code will be distributed to new Directors and employees and be distributed again to all Directors and employees on an annual basis. Directors and employees are required to sign the acknowledgment confirming they have received the Code, read it and understand it represents mandatory policies of the Company and agree to abide by it. The Company welcomes any suggestions to help improve its business conduct.

Directors and employees can report violations of the law or the Code by calling the Ethics and Compliance Hotline at (877) 814-9252. The Hotline is open 24 hours a day, 7 days a week, and is operated by an independent company. Directors and employees may remain anonymous and translators are available.

Antitrust & Competition

No Director or employee of the Company shall enter into any understanding, agreement, plan or scheme, express or implied, formal or informal, with any competitor to fix prices, contract terms, territories or customers. Authorized senior management of the Company must authorize any discussion with competitors in connection with a project in which the competitor is an alliance partner, joint venturer or subcontractor.

Directors and employees responsible for the conduct or practices of the Company which could in any way involve antitrust or anti-competitive activities should consult with their manager or another appropriate member of management about such matters.

There shall be no exception to this Policy, nor shall it be compromised or qualified by anyone acting for or on behalf of the Company.

Bribery

The Company prohibits payment to suppliers or customers in the form of bribes, kickbacks or payoffs. Directors and employees are also prohibited from receiving, directly or indirectly from a third party, anything of a significant value (other than salary or other ordinary compensation paid by the Company) in connection with a transaction entered into by the Company.

The Company also prohibits Directors and employees from paying any bribe, kickback or other similar unlawful payment to, or otherwise entering into a sensitive transaction with, any public official, political party, candidate for public office or other individual, to secure any contract,

concession or other favorable treatment for the Company or for personal gain. Any extraordinary payments, including extravagant entertainment or gifts of significant value (in general this means the cost will exceed □100), for the express purpose of obtaining or retaining business or unduly influencing some matter in favor of the Company is prohibited. Directors and employees who make such agreements are subject to appropriate action by the Company, as well as the legal conse□uences of applicable law.

Bribes, kickbacks and payoffs include, but are not limited to: gifts other than nominal value (in general this means the cost will not exceed □100); the uncompensated use of Company services, facilities or property; loans, or loan guarantees or other extensions of credit.

This Policy does not prohibit reasonable expenditures for meals and entertainment of suppliers and customers, which are an ordinary and customary business expense. These expenditures should be included on expense reports and approved under standard Company procedures.

Confidential Information

In carrying out the Company□s business, Directors and employees often learn confidential or proprietary information about the Company, its customers, suppliers or members. An unauthori□ed disclosure could be harmful to the Company or helpful to a competitor.

Therefore, no Director or employee entrusted with or otherwise knowledgeable about information of a confidential or proprietary nature shall disclose or use that information outside the Company or for personal gain, either during or after employment without the valid and proper written authori□ation from the Company.

The Company also works with proprietary data of suppliers, members and customers. The protection of such data is of the highest importance and must be discharged with the greatest care for the Company to merit the continued confidence of such persons. No Director or employee shall disclose or use confidential or proprietary information owned by someone other than the Company to non-employees without Company authori□ation, or disclose the information to others unless a need-to-know basis is established.

In general when describing or talking about the Company, it is safe to mention what we do and not how we do it or how much it costs.

Conflicts of Interest

Directors and employees have a duty to the Company to advance the Company□s legitimate interests when the opportunity to do so arises. Timely and proper disclosure of possible conflicts of interest that Directors and employees may have in connection with job duties and responsibilities is necessary to protect the best interests of the Company. Possible conflict of interest situations should be promptly and fully disclosed to the Company□s senior management.

A conflict of interest may occur if outside activities, personal financial interests, or other interests influence one's ability to make objective decisions in the course of their responsibilities as a Director or employee. A conflict of interest may also exist if the demands of any outside activities hinder or distract Directors or employees from the performance of their responsibilities or cause the individual to use Company resources for other than Company business.

The Company has always been concerned with outside business interests of its Directors and employees that might possibly conflict with the interests of the Company. The Company expects and requires Directors and employees to be honest and ethical in the handling of actual or apparent conflicts of interest between personal and business relationships.

A precise definition of what constitutes a conflict of interest is difficult. There are certain situations which the Company will always consider to be a conflict of interest. These occur if any person having a close personal relationship with the Director or employee, such as, spouse, parents, children, siblings, in-laws, any person living in the same home with the Director or employee or any business associate of the Director or employee:

1. Obtains a significant financial or other beneficial interest in one of the Company's suppliers, customers or competitors without first notifying the Company and obtaining written approval from authorized senior management of the Company;
2. Engages in a significant personal business transaction involving the Company for profit or gain, without first notifying the Company and obtaining written approval from authorized senior management of the Company;
3. Accepts money, gifts, hospitality, loans, guarantees of obligations or other special treatment from any supplier, customer or competitor of the Company;
4. Participates in any sale, loan or gift of Company property without first notifying the Company and obtaining written approval from authorized senior management of the Company;
5. Learns of a business opportunity through association with the Company and discloses it to a third party or invests in or takes the opportunity personally without first notifying the Company;
6. Uses corporate property, information, or position for personal gain; or
7. Competes with the Company.

Equal Opportunity Employer

The Company is an equal opportunity employer and makes employment decisions on the basis of merit. The Company wants to have the best available people in every job. Therefore, the Company does not discriminate, and does not permit its employees to discriminate against other employees or applicants because of race, color, religion, gender, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition, or any other basis protected by applicable federal, state, or local law. Equal employment opportunity

will be extended to all persons in all aspects of the employer-employee relationship, including recruitment, hiring, upgrading, training, promotion, transfer, compensation, benefits, discipline, layoff, recall and termination.

An employee who believes he or she has been or is being subjected to discrimination should bring this matter to the attention of his or her immediate supervisor, department head or Human Resources. If management receives a complaint of discrimination, they shall report the complaint immediately to Human Resources. Nothing in this policy requires any employee complaining of discrimination to present the matter to the person who is the subject of the complaint. All complaints of discrimination will be promptly investigated. The privacy of the persons involved will be protected, except to the extent necessary to conduct a proper investigation. If the investigation substantiates the complaint, immediate action will be taken to end the discrimination, prevent its recurrence and remedy the situation.

An employee who reports discrimination or participates in an investigation related to a complaint of discrimination shall not be retaliated against or adversely treated on the basis thereof.

Fraud & Similar Irregularities

Directors and employees are obligated to protect Company assets and ensure their efficient use. Theft, carelessness and waste of Company assets by Directors and employees may result in their termination and other corrective actions by the Company. Company assets shall be used only for the legitimate business purposes of the Company.

Fraud includes, but is not limited to, dishonest or fraudulent acts; embezzlement; misappropriation of assets; forgery or alteration of negotiable instruments such as Company checks and drafts; taking or using Company supplies or any other Company asset for a purpose other than Company business; unauthorized handling or reporting of Company transactions; and falsification of Company records or financial statements for personal reasons or any other reason.

Directors and employees are obligated to report any fraud, whether material or not to the Company. Reports will be investigated promptly and discreetly. Directors and employees will not suffer adverse consequences as a result of making such a report. However, failure to report a fraud will have a direct negative effect on that person's relations with the Company.

Policy Against Harassment

The Company is committed to providing a work environment that is free of unlawful discrimination and/or harassment. In keeping with this commitment, the Company maintains a strict policy prohibiting unlawful harassment in the workplace, including sexual harassment, by any employee and by any third parties such as patients, doctors, vendors or visitors. In addition, any harassment of an employee on the basis of race, color, religion, gender, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition or any other protected classification is also strictly prohibited.

The Company considers harassment a serious act of misconduct for which an employee will be disciplined, up to and including immediate discharge. Management who fail to report violations of the Company's Policy Against Harassment will be disciplined , up to and including suspension and termination of employment. The term "harassment" includes sexual, racial, ethnic, and other forms of harassment, including harassment based upon disability.

Some examples of what may be considered harassment, depending on facts and circumstances, include the following:

Sexual Harassment. Unwelcome sexual advances, requests for sexual favors, widespread sexual favoritism, and other verbal, physical or visual conduct of a sexual nature constitute unlawful sexual harassment if (i) submission to such conduct is made an explicit or implicit term or condition of employment; (ii) submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual; or (iii) such conduct has the purpose or effect of either (a) unreasonably interfering with an individual's work performance or (b) creating an intimidating, hostile, or offensive working environment. Sexual harassment includes gender harassment and harassment on the basis of pregnancy, childbirth or related medical conditions, and also includes sexual harassment of an employee of the same gender as the harasser.

Examples of conduct which may violate this Policy include, but are not limited to: offensive or unwelcome sexual flirtations, advances or propositions; threats and demands to submit to sexual requests; offering employment benefits in exchange for sexual favors; making or threatening reprisals after a negative response to sexual advances; widespread sexual favoritism; verbal abuse of a sexual nature; graphic verbal commentaries about an individual's body; sexually degrading words used to describe an individual; sexually-oriented jokes, e-mails, or written materials; visual conduct, including leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters; accessing sexually explicit, pornographic and/or socially offensive websites, chat rooms or other material on the internet or other computer systems; and the unwelcome physical touching of others.

Other Harassment. The Company also will not tolerate any harassment of an employee on the basis of race, gender, religion, color, national origin, sex, sexual orientation, sexual identity, transgender identity, age, ancestry, marital status, disability, medical condition, pregnancy, veteran's status, genetic predisposition or any other protected classification. Examples of such conduct which may violate this policy include, but are not limited to, verbal abuse of a racially derogatory nature; the use of racial or ethnic slurs; racially or ethnically disparaging words used to describe an individual; and racial, ethnic or other derogatory jokes, e-mail, written materials, drawings or cartoons which are racially or otherwise offensive.

Manager Training

As part of the Company's commitment to provide a harassment free workplace, the Company provides and requires training for all managers and supervisors on sexual harassment and other forms of prohibited harassment.

Complaint Procedure

If you believe that you have been discriminated against or you have been harassed by a co-worker, supervisor, patient, or vendor; have witnessed possible discrimination and/or harassment; or if you believe that the Company or another employee has violated any applicable law in the conduct of the Company's business, you have a duty to immediately bring the incident(s) to the attention of Human Resources, or to your supervisor or manager. Any supervisory or managerial employee who receives such a complaint must promptly report it to Human Resources. The description of the incident(s) can be given verbally or in writing.

The matter will be thoroughly investigated, with confidentiality maintained to the extent possible. The Company will promptly investigate the complaint and take appropriate remedial action. It is the obligation of all employees to cooperate fully in the investigation process.

The Company will take action to deter any future discrimination and/or harassment. The Company considers any discrimination and/or harassment to be a serious offense which can result in disciplinary action for the offender, up to and including termination. In addition, disciplinary action will be taken against any employee who attempts to discourage or prevent another employee from bringing discrimination, harassment and/or a violation of law to the attention of management.

Policy Against Retaliation

The Company strictly prohibits retaliation, coercion or intimidation against any person who has, in good faith, opposed harassment or discrimination, filed a complaint of harassment or discrimination, or participated in any proceeding involving a complaint of harassment or discrimination. Any employee who is found to have committed such retaliation will be subject to discipline, up to and including termination. Any employee who experiences or witnesses any conduct believed to be retaliatory should immediately follow the reporting procedures stated above.

Health & Safety

Health and safety is a primary goal of the Company. The Company will comply with all applicable laws to protect the health and safety of its employees in the workplace. Management shall take such actions as are reasonable and necessary to protect Directors, employees and the Company.

To maintain a safe workplace, employees must be safety conscious at all times. Employees must advise their Supervisor or Human Resources if they are aware of any condition presenting a danger so that corrective action may be taken to remove the danger.

Employees should report personal injury, however minor, to the Human Resources Department immediately. First aid kits are readily available in all work areas. In case of emergency, the first person in contact with the injured or ill worker will be responsible for seeking help. The Human Resources Department will assist in obtaining treatment for the injured worker.

Political Activities & Contributions

The Company encourages participation in the political process by its Directors and employees. The federal government and some states have, however, enacted laws regulating campaign contributions in order to limit the political influence of certain types of contributors, such as corporations, to political candidates and participation in political campaigns.

The Company will comply with applicable laws regulating political influence and campaign contributions. The Company believes strongly in the democratic political process and that its Directors and employees should take an active interest in fostering principles of good government in the communities in which they live. Directors and employees may spend their own time and funds supporting political candidates and issues but the Company will not reimburse them for time or funds used for political contributions.

No Director or employee shall apply pressure, direct or implied, that infringes upon an individual s right to decide whether, to whom and in what amount a personal political contribution is to be made. Directors and employees who represent the Company in political and governmental matters must comply with all laws that regulate corporate participation in public affairs.

When permitted by law and authori ed by authori ed senior management of the Company, Company funds and facilities may be used to inform or influence the voting public on an issue of importance to the business of the Company and its stockholders.

If a Director or employee is asked to make a political contribution and he or she has uestions regarding this policy or applicable law, they should consult with authori ed senior management of the Company.

Code of Business Conduct and Ethical Business Practice

Acknowledgment of Receipt

I certify that I have received the Prospect Medical Holdings, Inc. Code of Business Conduct and Ethical Business Practice, understand it represents mandatory policies of the Company and agree to abide by it.

Name (please print): _____

Signature: _____

Date: _____

EXHIBIT Q7-1

GWHN REQUEST FOR PROPOSAL

October 4, 2011

Advisory Engagement for

Greater Waterbury Health Network, Inc.

The Board of Directors ("Board") of Greater Waterbury Health Network, Inc. ("GWHN"), the parent of The Waterbury Hospital (the "Hospital"), is requesting proposals from financial advisory companies to provide a Fairness Evaluation in conjunction with its announced three-way joint venture (the "Transaction") with Saint Mary's Health System, Inc. and LHP Hospital Group, Inc.

Background

On March 4, 2011, GWHN engaged Cain Brothers and Co., LLC ("Cain Brothers") to explore strategic alternatives, which included a partnership, merger or sale. At the Board's direction, Cain Brothers requested proposals from a select group of organizations interested in this type of strategic relationship, with the core objective being the assurance of GWHN's continued long-term vigor as a provider of leading health care services to the Greater Waterbury community. Based on this overarching goal, GWHN evaluated potential partners who could demonstrably help in the achievement of the following objectives:

- Ensure Waterbury Hospital remains a viable health care entity, providing the highest safety and quality health care services to the Greater Waterbury communities for the long-term;
- Deploy repeatable and scalable tools and clinical care services to continually improve the health of the community;
- Provide access to sufficient capital to meet current and future capital needs while strengthening the balance sheet;
- Enhance the Hospital's medical staff by attracting and retaining physicians;
- Maintain high satisfaction scores by patients, physicians, employees and volunteers; and
- Continue charitable care delivery and funding.

After receiving proposals from potential partners, thoughtful diligence and intense negotiations, GWHN announced on August 23, 2011 that it had signed a letter of intent to join with the previously announced joint venture being formed between LHP Hospital Group, Inc. and Saint Mary's Health System, Inc.

The proposed transaction includes a commitment by the joint venture to construct a new medical center facility at a cost of approximately $400 million that will replace both The Waterbury Hospital and Saint Mary's Hospital.

Scope of Work:

Fairness Evaluation. The Transaction will require the Hospital to undertake the conversion process prescribed in Connecticut General Statutes § 19a-486 et seq. (the "Conversion Statute") The Board, to fulfill its fiduciary duties and its obligations under Conversion Statute requires an evaluation as to the appropriateness and fairness of the proposed Transaction. The evaluation must address each of the criteria specified in Connecticut General Statutes § 19a-486(c). The evaluation will be used to support the conclusion that GWHN will receive "fair market value" for its assets, which means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

The Board will utilize the Fairness Evaluation in the conversion process and it will be submitted as part of the Hospital's conversion application. Recognizing that the transaction conveys no cash consideration to GWHN at close, the valuation methodology must reference the intangible value to the Greater Waterbury community of maintaining the mission of GWHN and the value of the commitment of a replacement facility. The evaluation should include an assessment of the management agreement that the Joint Venture will enter into with an LHP affiliate to manage the hospitals' operations. Extrapolation of valuations from for-profit versus not-for-profit organizations and academic hospital systems versus community hospital systems are a requirement. The engagement is self-contained with a single work product.

Terms of Engagement

1. Remuneration: The Board will pay a fixed price for the Fairness Evaluation.

2. Exclusivity: In order to assure independence and avoidance of conflicts of interest, the advisor agrees not to perform or be contracted for any investment banking services for LHP Group, Saint Mary's or any patient care organization operating within 35 miles of GWHN for a period commencing at the time of engagement until the delivery of the Fairness Evaluation.

3. Non-Solicitation: The Board's primary motivation in entering into this agreement is to ensure that a Replacement Hospital is developed by the joint venture, thereby ensuring the highest quality care and delivery system is maintained in the Greater Waterbury Community. The greatest risk to GWHN as an enterprise would be for this transaction to fail to be consummated for any reason. The advisor must, therefore, be cognizant and become fluent in the confidentiality and exclusivity provisions in the Transaction, which essentially prohibit solicitation of any market contact as to any potential transaction or financing involving GWHN.

4. Acknowledgement: The advisor acknowledges that Cain Brothers is GWHN's investment banker, and no other investment banking services are required at this time.

Request for Proposal:

Please provide the Board four (4) sets of the following, in written format, no later than October 14, 2011.

- Firm Overview and Relevant Experience
- Biographies and Commitment of Proposed Team Members
- Diligence Needs
- Process Timeline
- Outline of Other Logistics & Coordination
- Compensation Structure
- Confirmation of Absence of any Conflicts of Interest

Direct your proposal to:

GREATER WATERBURY HEALTH NETWORK, INC.

64 Robbins Street

Waterbury CT 06708

Attention: Darlene Stromstad

EXHIBIT Q7-2

2011 RESPONSE FROM PRINCIPLE VALUATION, LLC TO GWHN REQUEST FOR PROPOSAL

RESPONSE TO RFP

FOR

FAIRNESS EVALUATION FOR CONVERSION OF GREATER WATERBURY HEALTH NETWORK, INC.

SUBMITTED TO:
GREATER WATERBURY HEALTH NETWORK, INC.
ATTENTION: MS. DARLENE STROMSTAD, FACHE
PRESIDENT/CEO
64 ROBBINS STREET
WATERBURY, CONNECTICUT 06708

Principle Valuation, LLC
PEOPLE AND VALUES YOU CAN TRUST

October 13, 2011

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Attention: Ms. Darlene Stromstad, FACHE
President/CEO

Re: Fairness Evaluation for Conversion of Greater Waterbury Health Network, Inc.

This letter serves as our proposal to provide the Board of Directors of Greater Waterbury Heath Network, Inc ("Board", or "GWHN") a Fairness Evaluation in conjunction with its announced three-way joint venture (the "Transaction") with St. Mary's Health System, Inc. and LHP Hospital Group, Inc.

PURPOSE AND BACKGROUND

We understand that the purpose of our analysis will be to provide the Board a fairness evaluation of the Transaction in order for the Board to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 119a-486 et seq. ("Conversion Statute").

SCOPE

In determining whether the consideration is fair from a financial point of view, we will specifically address the following valuation issues and considerations:

- Assess the "Fair Market Value" of the assets to be transferred by GWHN
- Assess the intangible value to the Greater Waterbury community of maintaining the of GWHN
- Assess the value from a financial point of view of the commitment to build a replacement facility
- Assess from a financial point of view the value of the management agreement that the joint venture will enter into with an LHP affiliate to manage the hospital's operations

In conducting these assessments the following considerations will be made:

- Review the terms associated with the Transaction

- Conduct a site visit to the Hospital to accurately describe and assess the condition of the assets to be transferred
- Review the historical and earning potential of the operating assets that GWHN intends to transfer
- Review and analyze the terms associated with the Management Agreement to be entered into with an affiliate of LHP
- Review the plans, budgets, and financial projections associated with the replacement facility
- Consider the overall market potential of the Waterbury Hospital and the combined joint venture separately and as combined
- Review and analyze other pertinent and necessary information necessary to arrive at our final opinions
- Review and extrapolate transactions that involved for-profit versus non-for-profit organizations and academic hospital systems versus community hospital systems

Fair Market Value for the purposes of this analysis will be defined as follows:

> The most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

PRINCIPLE VALUATION FIRM OVERVIEW, RELEVANT EXPERIENCE, AND TEAM MEMBERS

In 2007, Timothy Baker and David Felsenthal combined their 75 years of healthcare appraisal experience to form Principle Valuation, a firm dedicated to service the specialized needs of the healthcare community. In 2009, Patrick Simers joined as a Principal in the firm and added to the strength of the overall hospital valuation core with more than 25 years in the appraisal of Healthcare properties. All of the Principals of Principle Valuation,("PV" and "Principle"), have served as Presidents and Vice Presidents of many of the major healthcare valuation and healthcare consulting providers including Huron Consulting, American Appraisal, CBIZ, and Valuation Counselors, a valuation firm that Mr. Felsenthal had previously founded which was once recognized as the premier healthcare valuation firm in the industry. From inception our staff has continued to expand and we now have more than seventeen professional employees dedicated to the valuation of healthcare related entities.

Our business is generally segmented into three primary sectors; Hospital and Healthcare Enterprise Related Services, Healthcare Advisory Services; and Senior Housing Related Services.

In the Hospital and Healthcare Related services group, the primary emphasis is to prepare valuations to meet the regulatory guidelines associated with hospital transactions including Stark compliance, State Regulatory Requirements and Purchase Accounting. Valuations conducted in this sector generally include the valuation of hospitals and hospital systems, medical practices, joint ventures valuations, service agreements and other types of healthcare business arrangements. Another major focus of this group is the valuation of tangible and intangible assets associated with purchase accounting for Acute and Specialty Hospitals. Professionals in this group have real estate, medical equipment, and business enterprise expertise.

The Healthcare Advisory Services group is primarily responsible for the preparation of cost segregation studies, facility live analysis, and asset inventory and reconciliation reports. This group's personnel consists of staff members with engineering and tax expertise that assist our clients in reducing their overall tax liability and developing accurate property records that help our clients increase their overall bond ratings. Our Senior Housing Group focuses on the service needs of the senior housing industry. This group prepares market studies and valuations of nursing homes and assisted living residences. Their work is generally presented for financing and utilized to obtain conventional financing and through the HUD 232 program. Professionals in this group include real estate professionals who have detailed knowledge of the regulatory rules and reimbursement policies that dictate the seniors housing industry.

Particularly relevant engagements include fairness reviews and appraisals presented to comply with the Attorney General requirements in Georgia, Mississippi, Louisiana, Florida, Pennsylvania, and New Jersey. Direct hospital transfer assessments included Banks-Jackson-Commerce Hospital in Georgia; Baptist Memorial Hospital – North Mississippi in Mississippi; Ville Platte Medical Center and West Carroll Memorial Hospital in Louisiana; South Shore Hospital in Miami, Florida; and UPMC in Pittsburgh, Pennsylvania. We also recently assessed a hospital management agreement for Meadowlands Hospital Medical Center in New Jersey.

The primary parties that will be active in this engagement include Tim Baker, Patrick Simers, John Leary, and Mary Jo Duffy. As demonstrated by their Qualifications, each member of the team has more than 25 years in the valuation of healthcare enterprises and includes individuals with General Appraiser State Certifications, CFA's, and CPA's. These qualifications are included in the Addenda of this proposal.

DUE DILIGENCE DATA REQUIREMENTS

The following information will be initially and primarily required in order to complete the assignment:

- A Central Contact that is familiar with the overall operations and contemplated transaction. This person will serve as our primary contact and should be able to discuss the financial, and market environment for the assets under consideration. Further this person should have the ability to coordinate site visits with our staff with the Hospital
- Audited Financial Statements of GWHN and its primary operating units for the past three years along with the current year-to-date operations and budgets.
- Forecasted operations for the next three-five year period for Waterbury Hospital operations
- A current Balance Sheet of the Organization and an explanation of which assets are anticipated to transfer
- A copy of the current fixed asset ledger of the Hospital and its associated entities in an excel format
- A listing of all real estate property anticipated to transfer with the transaction; including the address of the property, a brief description of the improvements including its size and use, its associated tax parcel number, and the size of the underlying land parcel
- A copy of any Board Minutes that discussed the contemplated Transaction
- A copy of any reports or presentations that Cain Brother's prepared in making its overall recommendations to the Board
- A copy of the Medicare Cost Reports for the prior two fiscal periods
- A non-redacted version of the CON Application that St. Mary's and LHP provided to the State
- The Current Plans, Budgets, and Forecasted Financials for the Replacement Facility
- A copy of the Management Agreement anticipated between GWHN and LHP
- A Contact at LHP that we can discuss their overall business operations, history, capital resources, financials, etc.
- The Management and Organizational Structure associated with the Joint Venture
- Any Demographic, Market Research, or Competitive Surveys that were conducted to support the overall merger
- A brief write-up of the subject's current ownership and operational history
- Any other data that you feel is necessary that enhances our understanding of the Transaction

PROCESS TIMELINE, LOGISTICS, AND COORDINATION

We would anticipate the following general time line which would lead to an overall engagement completion by November 30, 2011.

- First Week (Oct. 21) — Award of contract and receipt of data requested
- Second Week (Oct. 28) — In-house review of data received and prepare plan for on-site visit to be conducted in the third week
- Third Week (Nov. 4) — Conduct on site visit October 31-November 3 This will primarily consist of a time spent verifying asset lists and getting descriptive data on improvements
- Fourth Week (Nov. 11) — In-Office Pricing, Research, and Development of Preliminary Estimates
- Fifth Week (Nov. 17) — Presentation of Preliminary Findings and Draft Report Development
- Sixth Week (Nov. 25) — Client Review of Draft Report (Thanksgiving Week)
- Seventh Week (Nov. 30) — Adjustments and Development of Final Report

We believe that this time line is reasonable based upon the overall effort and personnel that would be involved in this analysis. Should a tighter time frame be needed, we may be able to accommodate. All time estimates assume that all data requests are promptly received on an ongoing basis throughout the engagement process. We would immediately notify you should any delays in the receipt of information or other items beyond our control would push back these delivery timelines.

CONFIRMATION OF ABSENCE OF ANY CONFLICTS OF INTEREST

Neither Principle Valuation nor its staff members have any known conflict of interest with the parties to this Transaction or to the Transaction itself.

COMPENSATION STRUCTURE

Our fee for this engagement will be [redacted] inclusive of all expenses. We ask that a retainer of [redacted] be issued upon acceptance of this letter. We will subsequently bill [redacted] upon presentation of our initial findings and draft report. We anticipate all payments to be current prior to issuing our final report. Our final invoice, [redacted] will accompany our final report; or if no final report is desired, upon your indication that no final report is required. Our fee is in no way contingent upon the outcome of our conclusions. This fee is based on our estimate of professional services to be furnished, according to our understanding of your requirements; should the scope of these requirements change, Principle Valuation and Greater Waterbury Health Network, Inc. will mutually revise the fee to reflect those changes in services.

Fees include professional time for planning and executing the work through, and including, our final report. Should you require additional consultation based on your reviews of our work or those of your external auditors or your tax or other advisors, or any public presentation, testimony and appearance in front of any tribunal, agency or other body, subsequent payment will be required and we will bill for those services at our prevailing hourly rate for the personnel involved.

We reserve the right to withhold delivery of our preliminary conclusions or final report(s) if, when either of these is ready for delivery, any previously issued invoice remains unpaid. We reserve the right to issue interim or final invoices, as appropriate, should you delay the project and/or in the event that our preliminary or draft report has been in your possession for more than 30 days.

You have the right to terminate this assignment at any time, in which case there will be no further obligation on the part of either party to continue. In such event, you will be obligated to pay only for the actual time and charges accumulated through the date of cessation.

GWHN agrees to indemnify and hold harmless Principle Valuation, its employees, and representatives, collectively ("Principle") from and against any and all losses, claims, damages, or liabilities, joint or several, including all reasonable out-of-pocket expenses, fees, and disbursements of counsel incurred by Principle in defending any claim, action, or proceeding whether or not resulting in a liability to Principle to which they may become subject, caused by, arising out of or in connection with this engagement, including but not limited to, losses, claims, damages or liabilities caused by or arising out of any untrue statements of material fact contained in the information provided to Principle by GWHN or its advisors in connection with our engagement, or any omission to state any therein any material fact required or necessary to make the information not misleading in light of circumstances under which given, or any violation of the federal securities laws or the securities laws of any state, or otherwise arising out of our engagement hereunder except in respect to any matter as to which Principle shall have been adjudicated to have acted with gross negligence or willful malfeasance.

ACKNOWLEDGEMENT

We appreciate this opportunity to provide our recommendations for valuation-consulting services. We are uniquely qualified to perform this assignment, by virtue of our independence, experience, reputation, and expertise. We are committed to completing the work in an efficient and timely manner.

Due to the complexity of the assignment; if any of the terms, as highlighted, need to be discussed or refined please do not hesitate to call us as we would appreciate the opportunity to work with you on this important assignment.
But, if the content of this document correctly reflects your understanding of our agreement, please sign below and return the executed document and return the enclosed copy. This agreement shall remain open and valid for signature for 90 days from the issue date; however, any significant delay in executing this agreement could adversely impact our ability to meet the delivery commitments described herein. Please note we will be unable to start this engagement until we are in receipt of this signed acknowledgment. To avoid any delays in delivery, please

fax the signed acknowledgment to (312) 422-1515. Thereafter, please forward the original to us.

If you have any questions or comments, please call me at (770) 924-8811.

Respectfully submitted,

PRINCIPLE VALUATION, LLC

Patrick J. Simers
PJS/ms

CLIENT: GREATER WATERBURY HEALTH NETWORK, INC.

SIGNATURE(S): _____

NAME (PRINT OR TYPE): _____

TITLE: _____

DATE: _____

PHONE: _____

EXHIBITS

TIMOTHY H. BAKER
PRESIDENT

EXPERIENCE

Mr. Baker has been in the appraisal industry since 1981 with a concentration on healthcare and senior living properties. His valuation experience includes valuing the business enterprise, real estate, and personal property. Valuations have been performed on a national and international basis. Consulting engagements include market and financial feasibility studies.

Mr. Baker has experience in the valuation of numerous healthcare facilities including acute care, behavioral health, and rehabilitation hospitals. Senior living properties include nursing homes, assisted living facilities, and retirement centers. Other related operations include research facilities, healthcare leasing companies, physician practices, and medical office buildings. Mr. Baker has also provided consultations on market assessment, demand analysis, reimbursement issues, development of fixed asset records, and provided analysis of strategic opportunities. Valuation reports prepared by Mr. Baker have been used for several purposes including public offerings, litigation support, HUD 232 and 242 mortgage insurance programs, acquisition/divestitures, property tax purposes, state reimbursement, estate planning, and for internal management decision making.

PROFESSIONAL HISTORY

- 2007 to present – President, Principle Valuation, LLC.
- 2001 to 2007 - Senior Vice President, Wellspring Valuation, Ltd.
- 1997 to 2001 - Vice President, Marshall & Stevens National Healthcare Practice.
- 1992 to 1997 - Senior Manager, Capital Valuation Group, specializing in the valuation of the business and real estate of senior living and healthcare related facilities.
- 1981 to 1992 – Manager, Valuation Counselors where he was responsible for performing a multitude of appraisal and consulting services for clients specializing in business enterprise, real estate, and machinery and equipment.

PROFESSIONAL AFFILIATIONS

- Advisory Committee Member American Senior Housing Association
- Healthcare Financial Management Association
- American Health Lawyers Association
- Associate Member Appraisal Institute

EDUCATION LICENSES, AND DESIGNATIONS

- 1980 graduate of Bucknell University with a Bachelor of Science in Business Administration
- Certified General Real Estate Appraiser Maryland and New Jersey

TESTIMONY

- Testified as expert witness in California, Colorado, Connecticut, New Hampshire, New Jersey and Pennsylvania

PATRICK J. SIMERS
EXECUTIVE VICE PRESIDENT

EXPERIENCE

Mr. Simers has extensive experience in serving the valuation needs of the health-care industry. He has valued all tangible and intangible assets associated with health-care enterprises, including the capital stock of majority and minority share holdings; medical specialty and physician joint ventures; fee simple, leased fee, and leasehold interests in real estate for hospital systems, stand-alone hospital campuses, and medical office buildings; major and minor movable equipment; certificates of need; contractual agreements; and preferred provider arrangements.

Specific healthcare enterprises appraised include acute care hospital facilities, LTACH hospitals, psychiatric hospitals, rehab hospital facilities, single physician practices, multi-specialty practices, cath labs, diagnostic centers, cardiac care practices, home health agencies, nursing homes, assisted living facilities, and medical office buildings.

Mr. Simers has performed fair market value studies for purchase, sale, or financing; merger and acquisition consulting; negotiation of purchase price; fairness opinions; purchase price allocations; financial reporting; SEC reporting; Medicare regulatory requirements; Safe Harbor requirements; and 501(c)(3) private placement offerings.

PROFESSIONAL HISTORY

Mr. Simers began his appraisal career with Valuation Counselors in 1982 and held various consulting, business development, and management roles, including four years as president of Valuation Counselors, leading up to its merger with CBIZ Inc. Most recently, Mr. Simers has served as the National Director for Healthcare services for American Appraisal Associates where he spear-headed the development of healthcare services for this international appraisal firm.

Patrick J. Simers is Executive Vice President for Principle Valuation. He is responsible for the development and overall business plan for Principle's consulting and appraisal services to for-profit, nonprofit, and public health-care providers. Mr. Simers is located in Principle Valuation's Atlanta office.

PROFESSIONAL AFFILIATIONS

- American Health Lawyers Association
- Healthcare Financial Management Association

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Northern Illinois University with a Bachelor of Science in Finance and Economics
- Graduate of Moraine Valley College with a Associate in Arts in Business Administration
- Certified General Real Estate Appraiser in Georgia

JOHN L. LEARY, CFA

EXPERIENCE

Mr. Leary's hospital transaction experience consists of valuations for hospital acquisition and financing transactions in excess of $1 billion, SFAS 144 impairment studies for acute care hospitals, valuations for relative contributions of hospital operations to newly organized joint ventures, and valuations of certificate of need for new hospital construction.

His ambulatory surgery and diagnostic imaging center experience consists of valuation of surgery centers for hospital physician syndications, initial capitalization of joint venture between major metropolitan medical center and physician owned outpatient surgery center, and recapitalization of a multi-modality diagnostic imaging center owned by a partnership consisting of two medical centers and a radiology group.

Mr. Leary also has managed care experience that consists of an equity valuation of Medicaid Provider Service Network serving 50,000 Medicaid members, a SFAS 141 valuation of tangible and intangible assets for a managed care organization with a market capitalization of approximately $1.3 billion, and a purchase price allocation specialty pharmacy and pharmacy benefit management company totaling $1.5 billion.

Mr. Leary has also performed valuations of dialysis, home health, durable medical equipment, respiratory and infusion therapy operations, and physician practices

PROFESSIONAL HISTORY

- 1989 to 2011 - CBIZ Valuation Group, LLC — Atlanta, GA
  Southeastern Director of Financial Valuation Services
- 1987 – 1989 - Carnegie Securities Corporation — Atlanta, GA
  Vice President
- 1980 – 1987 - Storer Cable Communications — Atlanta, GA
  Regional Controller

EDUCATION AND ACCREDITATIONS

- 1978 – 1980 - Georgia State University — Atlanta, GA
  Masters of Business Administration with a concentration in finance
- 1974 – 1978 - Emory University — Atlanta, GA
  Bachelor of Arts with majors in Economics and Political Science
- Chartered Financial Analyst and Certified Public Accountant (inactive license)

MARY JO DUFFY

EXPERIENCE

Ms. Duffy brings 25 years of accounting, auditing, business valuation, business consulting and financial management to her clients. She has testified as an expert witness in deposition and trial, and advised clients on strategy, transactions and general business issues in addition to valuation issues

Ms. Duffy began her career with KPMG as an accountant and auditor. As CEO of Valuation Counselors, a national valuation firm, she provided valuation services to entities as diverse as boat manufacturers, grocery chains, technology ventures and healthcare providers. She served as a partner in a national CPA firm, responsible for appraisal and valuation services nationwide and was a member of the firm's Management Council.

As National Director of Financial Services to the healthcare industry for Coopers & Lybrand L.L.P., a predecessor firm of PricewaterhouseCoopers, Ms. Duffy was responsible for litigation, valuation, merger & acquisition, reorganization and other services to healthcare entities and assisted healthcare clients with matters involving providers, payers and related organizations. She later joined Ernst & Young's Healthcare Consulting practice specializing in physician networks, operations improvement, M&A strategy and post-merger integration. Her expertise in the healthcare arena includes advising providers on strategic options, negotiating transactions and assisting a Debtor in Possession in disposing of the assets, preparing a physician organization for doubling in size and an IPO, and developing integrated networks in academic medical centers and community delivery systems. She has also been the CFO of multi-specialty, multi-site healthcare provider.

PROFESSIONAL HISTORY

- Director, Acultas, Inc.
- National Director of Financial Services, Coopers & Lybrand
- CEO, Valuation Counselors
- Consultant, Ernst & Young Healthcare Consulting
- Certified Public Accountant and Auditor, KPMG.

PROFESSIONAL AFFILIATIONS

- Leadership Team Member Healthcare Task Force of GSCPAS
- Serves as Board Member for: Turning Point Women's Healthcare, The Childhood Autism Foundation and Emory Austin Resource Center
- Member, Illinois CPA Society
- Officer, Georgia Society of CPAS – Atlanta Chapter

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Georgetown University School of Business
- Certified Public Accountant

HONORABLE DESIGNATIONS

- Honored by Atlanta Magazine as one of Atlanta's outstanding business women.

HEALTHCARE SYSTEMS AND HOSPITALS
OUR PROFESSIONALS HAVE SERVICED SINCE 2000

HEALTHCARE SYSTEMS:	CITY	ST
Advocate Health Care	Oak Brook	IL
Ascension Health	St. Louis	MO
Aurora Health Care	Milwaukee	WI
Banner Health Systems	Phoenix	AZ
Baptist Health South Florida	Coral Gables	FL
Baylor Health Care System	Dallas	TX
Benefis Health System	Great Falls	MT
Capella Healthcare	Franklin	TN
Catholic Health East	Newtown Square	PA
Centura Health	Englewood	CO
CHRISTUS Health	Irving	TX
Community Health Systems, Inc.	Brentwood	TN
Community Memorial Health System	Ventura	CA
Daughters of Charity Health System	Los Altos Hills	CA
Elmhurst Memorial Healthcare	Elmhurst	IL
Envision Corp.	Scottsdale	AZ
Essent Healthcare Inc.	Nashville	TN
Gulf States Health Services	Baton Rouge	LA
Health Care REIT, Inc.	Toledo	OH
Health East	Minneapolis	MN
Health Management Associates	Naples	FL
Holistic Health Care, Inc.	Birmingham	AL
Hospital Sisters Health System	Springfield	IL
Ingalls Health System	Harvey	IL
Jewish Hospital & St. Mary's Healthcare	Louisville	KY
Landmark Hospitals	Cape Girardeau	MO
LifeCare Management Service	Plano	TX
LifePoint Hospitals, Inc.	Brentwood	TN
Memorial Healthcare System	Hollywood	FL
NorthShore University Health System	Evanston	IL
Presbyterian Healthcare Services	Albuquerque	NM
Provena Health	Chicago	IL
Rapid City Regional Hospital	Rapid City	SD
Renaissance Healthcare Systems	Houston	TX
Resurrection Health Care	Chicago	IL
Saint Barnabas Health System	Livingston	NJ

HEALTHCARE SYSTEMS:	CITY	ST
Saint Thomas Health Services	Nashville	TN
Sarasota Memorial Healthcare System	Sarasota	FL
Seton Family of Hospitals	Austin	TX
Sisters of St. Francis Health Services	Mishawaka	IN
Specialty Hospitals of America, LLC	Portsmouth	NH
SSM Regional Health Services/St Mary's Health Center	Jefferson City	MO
St. Anthony Memorial Health Centers	Michigan City	IN
St. Francis Health System	Pittsburgh	PA
St. Vincent's Health System	Birmingham	AL
Summa Health Systems	Akron	OH
Trinity Health	Novi	MI
Universal Health Services	King of Prussia	PA
University Hospital Health System - Cleveland	Cleveland	OH
University Hospital Health System - San Antonio	San Antonio	TX
Vanguard Health Systems	Nashville	TN
Vibra Healthcare	Mechanicsburg	PA

HOSPITALS:	CITY	ST
Carraway Burdick West Medical Center	Haleyville	AL
Carraway Northwest Medical Center	Winfield	AL
Crestwood Medical Center	Huntsville	AL
Hartselle Medical Center	Hartselle	AL
Parkway Medical Center	Decatur	AL
Russellville Hospital	Russellville	AL
Southern Cancer Center	Mobile	AL
Harris Hospital	Newport	AR
Helena Regional Medical Center	Helena	AR
National Park Medical Center	Hot Springs	AR
North Metro Medical Center	Jacksonville	AR
Siloam Springs Memorial Hospital	Siloam Springs	AR
St. Mary's Regional Medical Center	Russellville	AR
Holy Cross Hospital	Nogales	AZ
Plaza del Rio Campus	Sun City	AZ
St. Joseph Hospital	Tucson	AZ
St. Mary's Hospital	Tucson	AZ
Sun Health Del E. Webb Campus	Sun City West	AZ
Tuscan Medical Center	Tucson	AZ
William O. Boswell Hospital	Sun City	AZ
Cedars Sinai Medical Center	Los Angeles	CA

HOSPITALS:	CITY	ST
Community Hospital of the Monterey Peninsula	Monterey	CA
Downey Regional Medical Center	Downey	CA
Hemet Valley Medical Center	Hemet	CA
Hollywood Presbyterian Medical Center	Los Angeles	CA
Kentfield Rehabilitation & Specialty Hospital	Kentfield	CA
Lancaster General Hospital	Lancaster	CA
Menifee Valley Medical Center	Sun City	CA
Norris Comprehensive Cancer Center & Hospital	Los Angeles	CA
Parkview Community Hospital	Riverside	CA
Physicians' Hospital of Rancho California	Murrieta	CA
Robert H. Ballard Rehabilitation Hospital	San Bernardino	CA
San Joaquin Valley Rehabilitation Hospital	Fresno	CA
USC University Hospital	Los Angeles	CA
Ventura Hospital	Ventura	CA
Lutheran Campus ASC LLC	Wheat Ridge	CO
OrthoColorado Hospital	Lakewood	CO
Penrose Hospital	Colorado Springs	CO
St. Anthony North Hospital	Westminster	CO
St. Mary-Corwin Medical Center	Pueblo	CO
St. Thomas More Hospital	Canon City	CO
Capital Hills Hospital	Sharon	CT
Greenwich Hospital	Greenwich	CT
Sharon Hospital	Sharon	CT
Greater Southeast Community Hospital	Washington	DC
Providence Hospital	Washington	DC
Specialty Hospital of Washington-Hadley	Washington	DC
Boca Raton Community Hospital	Miami	FL
Baptist Hospitals of Miami	Miami	FL
Bonita Community Health Center	Boca Raton	FL
East Point Hospital	Bonita Springs	FL
Fishermen's Hospital	Marathon	FL
Health Central Hospital	Ocoee	FL
HealthSouth Ridgelake Hospital	Sarasota	FL
Holy Cross Hospital	Marathon	FL
Homestead Hospital	Fort Lauderdale	FL
Jacksonville Medical Center	Homestead	FL
Mercy Hospital	Miami	FL
Memorial Hospital Pembroke	Jacksonville	FL
Memorial Hospital of South Broward	Pembroke Pines	FL

HOSPITALS:	CITY	ST
Memorial Regional Hospital	Hollywood	FL
Northwest Florida Community Hospital	Chipley	FL
Park Royal Hospital	Ft. Myers	FL
Santa Rosa Medical Center	Milton	FL
Shands Lake Shore	Lake City	FL
Shands Live Oak	Live Oak	FL
Shands Starke	Starke	FL
West Kendell Baptist Hospital	Kendell	FL
Wuesthoff Medical Center-Rockledge	Rockledge	FL
Wuesthoff Medical Center-Melbourne	Melbourne	FL
Athens Long-Term Acute Care Hospital	Athens	GA
Banks-Jackson-Commerce Hospital and Nursing Home	Atlanta	GA
Grady Memorial Hospital	Atlanta	GA
Hamilton Medical Center	Dalton	GA
Complex Care Hospital of Idaho	Meridian	ID
Advocate Bethany Hospital	Chicago	IL
Advocate BroMenn Regional Medical Center	Normal	IL
Advocate Christ Medical Center	Oak Lawn	IL
Advocate Condell Medical Center	Libertyville	IL
Advocate Good Samaritan Center	Downers Grove	IL
Advocate Illinois Masonic Medical Center	Chicago	IL
Advocate Lutheran General Hospital	Park Ridge	IL
Advocate South Suburban Hospital	Hazel Crest	IL
Elmhurst Memorial Hospital	Elmhurst	IL
Evanston Northwestern Health Care	Evanston	IL
Good Shepherd Hospital	Barrington	IL
Gottlieb Memorial Hospital	Melrose Park	IL
Holy Family Medical Center	Des Plaines	IL
Marshall Browning Hospital	DuQuoin	IL
Mercy Hospital & Medical Center	Chicago	IL
Northwest Community Hospital	Arlington Heights	IL
Our Lady of Resurrection Medical Center	Chicago	IL
Palos Community Hospital	Palos Heights	IL
Provena St. Joseph Hospital	Elgin	IL
Provena St. Mary Hospital	Aurora	IL
Resurrection Medical Center	Chicago	IL
Rockford Memorial Hospital	Rockford	IL
Rush-Copley Medical Center	Aurora	IL
Rush University Medical Center	Chicago	IL

HOSPITALS:	CITY	ST
Saint Anthony Hospital	Chicago	IL
Saint Joseph's Medical Center	Joliet	IL
Sherman Hospital	Elgin	IL
St. Anthony's Memorial Hospital	Effingham	IL
St. Elizabeth Hospital	Chicago	IL
St. Elizabeth Medical Center	Granite City	IL
St. Francis Hospital	Evanston	IL
St. James Hospital & Health Center	Chicago Heights	IL
St. John's Hospital	Springfield	IL
St. Joseph Hospital	Chicago	IL
St. Mary's Hospital	Decatur	IL
St. Mary's Hospital	Kankakee	IL
St. Mary's Hospital	Streator	IL
St. Mary of Nazareth Hospital	Chicago	IL
Swedish American Hospital	Rockford	IL
The Hospital for Specialty Care	Chicago	IL
Bluffton Regional Medical Center	Bluffton	IN
Dukes Memorial Hospital	Peru	IN
DuPont Hospital	Fort Wayne	IN
Elkhart General Hospital	Elkhart	IN
Franciscan Point Saint Anthony Health Complex	Crown Point	IN
Franciscan Physician Hospital	Munster	IN
Heartland Memorial Hospital	Munster	IN
Kosciusko Community Hospital	Warsaw	IN
Lutheran Hospital of Indiana	Fort Wayne	IN
Monroe Hospital	Bloomington	IN
Morgan Hospital and Medical Center	Martinsville	IN
OP Pavilion	Dyer	IN
Pinnacle Hospital	Crown Point	IN
Pulaski Memorial Hospital	Winamac	IN
Rehabilitation Hospital of Fort Wayne	Fort Wayne	IN
Starke Memorial Hospital	Knox	IN
St. Anthony Memorial	Michigan City	IN
St. Francis Hospital - Mooresville	Mooresville	IN
St. Francis Hospitals & Health Centers - South Campus	Indianapolis	IN
St. Joseph Hospital	Fort Wayne	IN
St. Joseph Regional Medical Center	Mishawaka	IN
St. Margaret Mercy Hospital	Hammond	IN
St. Vincent Indianapolis Hospital	Indianapolis	IN

HOSPITALS:	CITY	ST
Shawnee Mission Medical Center	Shawnee Mission	KS
Western Plaines Medical Complex	Dodge City	KS
Jewish Hospital	Louisville	KY
Jewish Hospital Shelbyville	Shelbyville	KY
Southern Kentucky Rehabilitation Hospital	Bowling Green	KY
Avoyelles Hospital	Marksville	LA
Baton Rouge General Medical Center	Baton Rouge	LA
CHRISTUS Coushatta Health Care Center	Coushatta	LA
CHRISTUS Schumpert Highland	Shreveport	LA
CHRISTUS Schumpert St. Mary Place	Shreveport	LA
CHRISTUS St. Francis Cabrini Hospital	Alexandria	LA
CHRISTUS St. Patrick Hospital	Lake Charles	LA
HealthSouth Specialty Hospital of North Louisiana	Ruston	LA
Oakdale Community Hospital	Oakdale	LA
Presbyterian Intercommunity Hospital	Lafayette	LA
River West Medical Center	Plaquemine	LA
Sabine Medical Center	Many	LA
Merrimack Valley Hospital	Haverhill	MA
New Bedford Rehabilitation Hospital	New Bedford	MA
Hillsdale Community Health Center	Hillsdale	MI
St. Joseph Mercy Hospital	Ypsilanti	MI
Truvista Surgery Center	Troy	MI
St. Joseph's Hospital	St. Paul	MN
Cape Girardeau Long-Term Acute Care Hospital	Cape Girardeau	MO
Crossroads Regional Hospital	Wentzville	MO
Franciscan Sisters of Our Lady of Perpetual Help of Ohio	St. Louis	MO
Joplin Long-Term Acute Care Hospital	Joplin	MO
Mineral Area Regional Medical Center	Farmington	MO
Northcrest Regional Medical Center	Kirksville	MO
North Kansas City Hospital	North Kansas City	MO
SSM Regional Health Services	Jefferson City	MO
St. Alexius Hospital - Broadway Campus	St. Louis	MO
St. Alexius Hospital - Jefferson Campus	St. Louis	MO
St. Anthony's Medical Center	St. Louis	MO
St. Mary's Health Center	Jefferson City	MO
St. Mary's Hospital of Blue Springs	Blue Springs	MO
Oxford Lafayette Medical Center	Oxford	MS
Marlton Rehabilitation Hospital	Marlton	NJ
Meadowlands Hospital Medical Center	Secaucus	NJ

HOSPITALS:	CITY	ST
Memorial Hospital of Salem County	Salem	NJ
Mountainside Hospital	Montclair	NJ
Muhlenberg Medical Center	Plainfield	NJ
St. Michael's Medical Center	Newark	NJ
Presbyterian Hospital	Albuquerque	NM
Presbyterian North Side Hospital	Albuquerque	NM
HealthSouth Hospital at Tenaya	Las Vegas	NV
Deaconess Center	Buffalo	NY
St. Mary's Hospital	Amsterdam	NY
Brown County Regional Hospital	Georgetown	OH
Conneaut Medical Center	Conneaut	OH
Geneva Medical Center	Geneva	OH
Hillside Rehabilitation Hospital	Warren	OH
Mahoning Valley Hospital	Warren	OH
Mahoning Valley Hospital LTAC	Boardman	OH
Select Specialty Hospital	Akron	OH
St. Thomas Hospital	Akron	OH
Summa Health	Akron	OH
Logan Medical Center	Guthrie	OK
Willamette Valley Medical Center	McMinnville	OR
Chestnut Hill Healthcare	Philadelphia	PA
HealthSouth Hospital of Pittsburgh	Monroeville	PA
HealthSouth Regional Specialty Hospital	Mechanicsburg	PA
Lock Haven Hospital	Lock Haven	PA
Memorial Hospital	Towanda	PA
Mercy Hospital	Scranton	PA
Mercy Special Care Hospital – Nanticoke	Nanticoke	PA
Mercy Tyler Hospital	Tunkhannock	PA
Moses Taylor Hospital	Scranton	PA
Southwest Regional Medical Center	Waynesburg	PA
St. Francis Hospital Cranberry	Cranberry	PA
St. Francis Hospital of New Castle	New Castle	PA
St. Francis Medical Center	Pittsburgh	PA
Lookout Memorial Hospital	Spearfish	SD
Sturgis Community Health Care Center	Sturgis	SD
Baptist Hospital of Cocke County	Newport	TN
Fentress County General Hospital	Jamestown	TN
Gateway Medical Center	Clarksville	TN
Haywood Park Community Hospital	Brownsville	TN

HOSPITALS:	CITY	ST
McKenzie Regional Hospital	McKenzie	TN
Mercy Medical Center North	Powell	TN
Mercy Medical Center St. Mary's	Knoxville	TN
Mercy Medical Center West	Knoxville	TN
Methodist Healthcare McNairy	Selmer	TN
Methodist Healthcare Volunteer Hospital	Martin	TN
Methodist Healthcare-Brownsville	Brownsville	TN
Methodist Healthcare-Dyersburg	Dyersburg	TN
Methodist Healthcare-Jackson	Jackson	TN
Methodist Healthcare-McKenzie	McKenzie	TN
Methodist Healthcare-Lexington	Lexington	TN
Middle Tennessee Medical Center	Murphysboro	TN
North Coast Medical Center	Springfield	TN
St. Mary's Jefferson Memorial Hospital	Jefferson City	TN
St. Mary's Medical Center of Campbell County	LaFollette	TN
St. Mary's Medical Center of Scott County	Oneida	TN
White County Community Hospital	Sparta	TN
Baptist Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Children's Hospital	San Antonio	TX
CHRISTUS Santa Rosa Hospital-City Centre	San Antonio	TX
CHRISTUS Santa Rosa Hospital-Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Hospital-New Braunfels	New Braunfels	TX
CHRISTUS Santa Rosa Hospital-Westover Hills	San Antonio	TX
CHRISTUS Spohn Hospital Alice	Alice	TX
CHRISTUS Spohn Hospital Corpus Christi Memorial	Corpus Christi	TX
CHRISTUS Spohn Hospital Corpus Christi South	Corpus Christi	TX
CHRISTUS Spohn Hospital Kleberg	Kingsville	TX
Dell Children's Medical Center	Austin	TX
East El Paso Physicians' Medical Center	El Paso	TX
Gulf Coast Medical Center	Wharton	TX
HealthSouth Hospital of Houston	Houston	TX
Highland Medical Center	Lubbock	TX
LifeCare Hospitals of Ft. Worth	Ft. Worth	TX
LifeCare Hospitals of Plano	Plano	TX
LifeCare Hospitals of San Antonio	San Antonio	TX
Longview Regional Medical Center	Longview	TX
Medical Center of Mesquite	Mesquite	TX
North Central Baptist Hospital	San Antonio	TX
Northeast Baptist Hospital	San Antonio	TX

HOSPITALS:	CITY	ST
Renaissance Hospital of Groves	Groves	TX
Renaissance Hospital of Dallas	Dallas	TX
Renaissance Hospital of Houston	Houston	TX
San Angelo Community Medical Center	San Angelo	TX
Seton Medical Center Williamson	Round Rock	TX
Southeast Baptist Hospital	San Antonio	TX
South Texas Spine & Surgical Hospital	San Antonio	TX
St. Luke's Baptist Hospital	San Antonio	TX
Texas Specialty Hospital	Houston	TX
Trinity Community Medical Center of Brenham	Brenham	TX
Trinity Medical Center	Carrollton	TX
Jordan Valley	West Jordan	UT
Rocky Mountain Medical Center	Salt Lake City	UT
Lee Community Hospital	Pennington Gap	VA
St. Mary's Hospital	Norton	VA
Empire Health Services	Spokane	WA
Lourdes Medical Center	Pasco	WA
St. Joseph Regional Medical Center	Lewiston	WA
Valley Medical Center	Renton	WA
LifeCare Hospitals of Wisconsin	Pewaukee	WI
Aurora Medical Center Grafton	Grafton	WI
Aurora Medical Center Oshkosh	Oshkosh	WI
Aurora Medical Center Summit	Summit	WI
Sacred Heart Hospital	Eau Claire	WI
St. Joseph's Hospital	Chippewa Falls	WI
St. Mary's Hospital Medical Center	Green Bay	WI
St. Nicolas Hospital	Sheboygan	WI
St. Vincent Hospital	Green Bay	WI
Bluefield Regional Medical Center	Bluefield	WV
Charleston Area Medical Center	Charleston	WV
Thomas Memorial Hospital	South Charleston	WV

EXHIBIT Q7-3

ADDITIONAL RESPONSES TO GWHN REQUEST FOR PROPOSAL

HOULIHAN LOKEY

October 14, 2011

Darlene Stromstad, FACHE
Greater Waterbury Health Network, Inc.
64 Robbins St.
Waterbury, CT 06708

Re: Fairness Opinion Proposal

Dear Ms. Stromstad:

We appreciate your interest in Houlihan Lokey Howard & Zukin ("Houlihan Lokey") and our financial advisory and fairness opinion services. We understand that Greater Waterbury Health Network, Inc. (the "Company") is contemplating a transaction in which the Company would enter into a joint venture (the "Joint Venture") with LHP Hospital Group, Inc. ("LHP") and Saint Mary's Health System, Inc. ("Saint Mary's") to build and operate a new hospital (the "Transaction"). Under proposed terms of the Transaction, LHP would fund the construction of the new hospital with a cost of approximately $400 million and both St. Mary's and LHP would close their existing facilities. We understand that the Company would receive a 10% interest in the Joint Venture operating the hospital and receive no cash consideration. We further understand that LHP would receive an 80% interest in the Joint Venture and St. Mary's would receive a 10% interest.

Houlihan Lokey is an international investment banking firm and is generally acknowledged as the leading M&A fairness opinion advisor in the U.S. The firm is uniquely qualified to provide independent financial advisory services to the Company's Board of Directors (the "Board") as it considers the Transaction. This advisory role is one that Houlihan Lokey has played in several other transactions.

This proposal letter introduces you to Houlihan Lokey and outlines our firm's capabilities and fairness opinion services. We have also provided you under separate cover a Presentation of Qualifications describing our experience in greater detail, including our fairness opinion and healthcare industry credentials, and professional biographies of the individuals who will work on this engagement.

Firm Overview

Houlihan Lokey provides a wide range of advisory services, including mergers and acquisitions, private placements of debt and equity, valuation services including transaction opinions, and financial restructuring. We have over 800 employees located in 14 offices throughout the world, including Los Angeles, New York, Chicago, San Francisco, Dallas, Atlanta, Minneapolis, Washington, D.C., London, Paris, Frankfurt, Hong Kong, Tokyo and Beijing. We annually serve more than 1,000 clients worldwide, ranging from closely held companies to Global 500 corporations. The firm is recognized as one of the leading M&A fairness opinion advisors, consistently ranking as one of the most active firms according to M&A league tables.

Overview of Fairness Opinion Practice

Houlihan Lokey has developed an outstanding reputation in advising on fairness opinions and analyses to boards of directors of both public and private companies, special or independent committees, partnerships, foundations, interested shareholder groups and trustees. According to *Thomson Reuters*, Houlihan Lokey was ranked as the number one M&A fairness opinion advisor over the past ten years in transactions involving U.S. companies. The firm has rendered fairness opinions in every conceivable change of control transaction, including mergers, sales, divestitures and going private transactions. In other contexts, we have rendered fairness opinions for mergers of equals, exchange offers, private placements of public equity ("PIPEs"), down round financings, recapitalizations, sales of securities, and leveraged purchases.

As a financial advisor, Houlihan Lokey brings a broad array of applicable transaction experience to each client it serves and treats each engagement with the strictest confidentiality, as any breach can have a devastating impact on the ultimate purchase price and success of closure. Houlihan Lokey's clients have come to rely on the firm for its technical expertise, unimpeachable credibility and independent posture in all of its opinions. The accompanying Presentation of Qualifications summarizes our expertise and provides an extensive list of representative fairness opinion engagements. These engagements validate our firm's independence, responsiveness, and expertise at rendering opinions, all of which make us the ideal candidate to advise the Board on the fairness of the Transaction.

In assessing the Transaction, we will conduct a comprehensive investigation of the Company, the local healthcare market, the expected operations of the Joint Venture and the economics and benefits of the Transaction. Our due diligence process is very thorough, consisting of interviews of senior and operating management of the Company, interviews with the Transaction advisors, and analysis and review of information provided by the Company and its advisors. We believe our technical capabilities are unmatched, as we conduct rigorous analysis in connection with each of our fairness engagements. Finally, the analysis and conclusions developed by the engagement team culminate with an internal presentation to our Fairness Review Committee, which consists of several senior officers of Houlihan Lokey (excluding any engagement team members). The Fairness Review Committee conducts an extensive review of the fairness analysis prior to the delivery of a fairness opinion and presentation to the Board.

Healthcare Expertise

Houlihan Lokey has a dedicated global team of investment bankers who are focused on the healthcare industry with specific expertise in the hospital management space. The team has extensive expertise and experience in advising on M&A transactions, financial restructurings, and providing counsel for strategic decision making. We have numerous longstanding relationships with board members and executives of both quoted and private companies, in addition to contacts with a broad range of associated investors and lenders. We have included a specific section detailing our healthcare expertise in the Presentation of Qualifications.

Scope of Services and Proposed Fees

The engagement team will interface with the Board and its advisors throughout the engagement, with the Board ultimately receiving a signed fairness opinion, along with a presentation summarizing our analysis and conclusions. The fairness opinion will address the consideration received by the Company in the form of a 10% interest in the Joint Venture. In addition to the fairness opinion, we will address: (1) the

intangible benefit to the Waterbury community of maintaining the mission of the Company and the commitment of a replacement hospital; (2) an assessment of the management agreement to be entered between the Joint Venture and LHP; and (3) a comparison of valuations between for-profit, not-for-profit, academic and community hospital systems.

Although the opinion and analyses are used by the Board to exercise its fiduciary duties and will be included in its filing to the State of Connecticut, we deliver even greater value to the Board in providing the full backing of our firm in the event that there is any subsequent scrutiny by the State Attorney General.

Houlihan Lokey provides its clients with exceptional expertise, senior-level attention and responsive execution. Ben Buettell and Michael DeLuke will be the team leaders for this engagement with significant assistance from Gary Brewster. Ben is a Managing Director and co-head of the firm's Fairness and Solvency Opinion Practice. Michael is a Director in the Financial Advisory Services practice and has significant healthcare experience in the hospital sector. We will be supported by additional professionals from our healthcare practice and others. We believe there is no better-suited engagement team to assist the Board in its deliberations in connection with the Transaction.

Typically, the fees for our services depend upon the nature of the engagement, the perceived risk of the requested opinion, the timing and complexity of the transaction, and the associated staffing requirements. Based on our preliminary understanding of the Transaction, we propose a fee of $300,000. In addition to the professional fees outlined above, Houlihan Lokey would be entitled to the reimbursement of its necessary and reasonable out-of-pocket expenses, including any reasonable fees for outside legal counsel. The fee would be payable by the Company as follows: (i) upon execution of Houlihan Lokey's retainer agreement, a non-refundable payment of [redacted] and (ii) the remainder of the fee upon delivery of our opinion.

Other Requested Information

Houlihan Lokey does not have any conflicts with the parties in the Transaction.

We propose a timeline for the delivery of a draft report of three weeks from the receipt of requested materials and have included a preliminary information list as Attachment A. We believe Company management would have ready access to the majority of items on the list but can work with management as needed to complete our information needs. Our proposed timeline is based on the following:

- Week One – Review of information and initial due diligence
- Week Two – Preparation of valuation and other analyses
- Week Three – Preparation of presentation materials and internal review

Our initial due diligence would include a site visit and discussions with the key financial, strategic and operational team of the Company consisting of four to eight hours. We would also request interview(s) with LHP either telephonically or on-site that might last one to two hours. After initial diligence, we would likely have continued follow-up via telephone or e-mail via the key contact points as designated by the Company.

In Closing

We trust that this proposal and the accompanying presentation set forth our credentials and demonstrate that Houlihan Lokey is uniquely qualified to assist the Board. We look forward to the opportunity to work with you on this important transaction. Please do not hesitate to contact us at your convenience to discuss this proposal.

Regards,

Gary Brewster	Ben Buettell	Michael DeLuke
Managing Director	Managing Director	Director

cc: Ann H. Zucker, Carmody & Torrance LLP

Attachment A

Greater Waterbury Health Network
Diligence Needs

While we realize that you may not be able to provide us with all the information that has been listed, this request should serve as guidance for developing the information we will need for the successful completion of the analysis. If you have any questions regarding the items on the list, please contact Michael DeLuke at 214-220-8487.

1. Audited fiscal year financial statements (i.e., balance sheet, income statement, and statement of cash flows) for the prior three years. Please provide historical financials in internal management-style reports formatted to include gross revenues by inpatient/outpatient/etc. and detail behind revenue deductions.

2. Latest interim year-to-date financial information with comparison to the same period last year.

3. Operating and statistical utilization information for the prior three years and interim periods above.

4. Operating budgets for the remainder of 2011 and the next 5 years.

5. Details of any non-recurring income or expense items during the prior 3 years.

6. Hospital's most recent business plan including any long-term financial or operating projections.

7. Estimates of the following (may be included in business plan):
    a. Net revenue growth expected for the next five years
    b. Operating and non-operating expense growth
    c. Any estimates on long-term expected utilization, occupancy, FTE levels, etc.
    d. Expectations of growth or changes in services (outpatient, home health, ER, etc.)
    e. Expectations and impacts of changes in mix of beds, services, etc.

8. Information memorandum or other information prepared by Cain Brothers during the prior sales process.

9. Signed letter of intent and draft formation/operating agreements regarding the joint venture.

10. When available, draft management agreement between the joint venture and LHP.

11. Details and status of any ongoing capital projects at the facilities.

12. Comments on any physical plant limitations or functional constraints on the delivery of services.

13. Most recently compiled economic and demographic information for the market service area.

14. Comments on physician relations, retention, recruitment, etc. (may be included in business plan).

15. Details on any non-operating assets such as restricted cash/securities or undeveloped land.

16. If applicable, a summary of any outstanding contingencies, liabilities, litigation, etc. not described in the financial data provided. This includes detail of any non-normal amounts receivable or payable to Medicare and other fiscal intermediaries.

Greater Waterbury Health Network | October 2011

Presentation of Qualifications

Confidential

HOULIHAN LOKEY

www.HL.com U.S. 800.788.5300 Europe +44.20.7839.3355 Hong Kong +852.3551.2300 Japan +81.3.4577.6000

Los Angeles • New York • Chicago • San Francisco • Minneapolis • Washington, D.C. • Dallas • Atlanta • London • Paris • Frankfurt • Hong Kong • Tokyo • Beijing

Greater Waterbury Health Network

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Overview of Houlihan Lokey / Healthcare Group	18
Houlihan Execution and Support Team Biographies	32

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Houlihan Lokey Overview

A Leading Investment Banking Firm

HOULIHAN LOKEY

Corporate Finance

Mergers and Acquisitions

- Sellside & Buyside Transactions
- Leveraged Transactions
- Minority Equity Transactions

Capital Markets

- Debt & Equity Private Placements
- High Yield
- PIPEs Financings
- Liabilities Management
- Special Situations Advisory

Financial Advisory

- Fairness Opinions
- Solvency Opinions
- Valuation Opinions
- Transaction Advisory Services
- Tax & Financial Reporting Valuation
- Portfolio Valuation & Advisory Services
- Derivatives Valuation & Advisory Services
- Dispute Resolution & Financial Expert Opinions

Financial Restructuring

- Chapter 11 Planning
- Restructuring Debt and Equity
- Debtor-in-Possession ("DIP") Financing
- Exchange Offers
- Plans of Reorganization
- Distressed Mergers and Acquisitions

Ranked Among Top 10 M&A Advisors for Ten Straight Years

2010 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	117
2	Goldman Sachs & Co	99
3	Lazard	82
4	Bank of America Merrill Lynch	77
5	JP Morgan	73

Source: Thomson Reuters

M&A Advisor's
2010 Valuation Firm of the Year

M&A Fairness Advisory Rankings
Announced or Completed Deals – 2001 to 2010

Rank	Advisor	Number of Deals
1	Houlihan Lokey	642
2	JP Morgan	516
3	Bank of America Merrill Lynch	368
4	Morgan Stanley	323
5	UBS	304

Source: Thomson Reuters

No. 1 Investment Banking
Restructuring Advisor

Global Distressed Debt & Bankruptcy
Restructuring Rankings 2010

Rank	Advisor	Number of Deals
1	Houlihan Lokey	74
2	Lazard	58
3	Rothschild	50
4	Moelis & Co.	28
5	Blackstone Group LP	25

Source: Thomson Reuters, January 2011.

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Recent Highlights and Accomplishments

Closed More Middle-Market Deals Than Any Other Firm

2010

2010 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	117
2	Goldman Sachs & Co	82
3	Lazard	80
4	Bank of America Merrill Lynch	77
5	JPMorgan	73
6	Jefferies & Co Inc	72
7	Morgan Stanley	59
8	Credit Suisse	57
9	Barclays Capital	56
10	RBC Capital Markets	53

Source: Thomson Reuters

2009

2009 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	77
2	Goldman Sachs & Co	57
3	Bank of America Merrill Lynch	55
4	JPMorgan	53
5	Lazard	51
6	Credit Suisse	50
6	Morgan Stanley	50
8	UBS	40
9	RBC Capital Markets	38
10	Citi	36
10	Deutsche Bank AG	36

* denotes tie.
Source: Thomson Reuters

2008

2008 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	112
2	Goldman Sachs & Co	87
3	RBC Capital	85
4	Credit Suisse	78
5	Merrill Lynch	62
6	* Morgan Stanley	60
7	* Lazard	59
7	* UBS	59
9	Citi	57
10	Jefferies & Co Inc	56

* denotes tie.
Source: Thomson Reuters

2007

2007 M&A Advisory Rankings
U.S. Deals Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	111
2	Goldman Sachs & Co	102
3	* Citi	102
3	* Lazard	102
5	Jefferies & Co Inc	92
6	UBS	88
7	* Bear Stearns	87
7	* JPMorgan	87
9	Morgan Stanley	74
10	RBC Capital Markets	71

* denotes tie.
Source: Thomson Financial

Winner of Numerous Industry Awards

- 2010 Mid Market Bank of the Year
  Investment Dealers' Digest
  - Awarded by Investor's Dealers Digest on January 28, 2011
- 2010 Mid-market Financial Advisor of the Year – United States
  - Awarded by Financial Times and Mergermarket on December 13, 2010
- 2010 Investment Bank of the Year – North America
  - Awarded by InterContinental Finance Magazine on September 20, 2010
- 2009 Investment Banking Firm of the Year
  - Awarded by M&A Advisor on December 14, 2009

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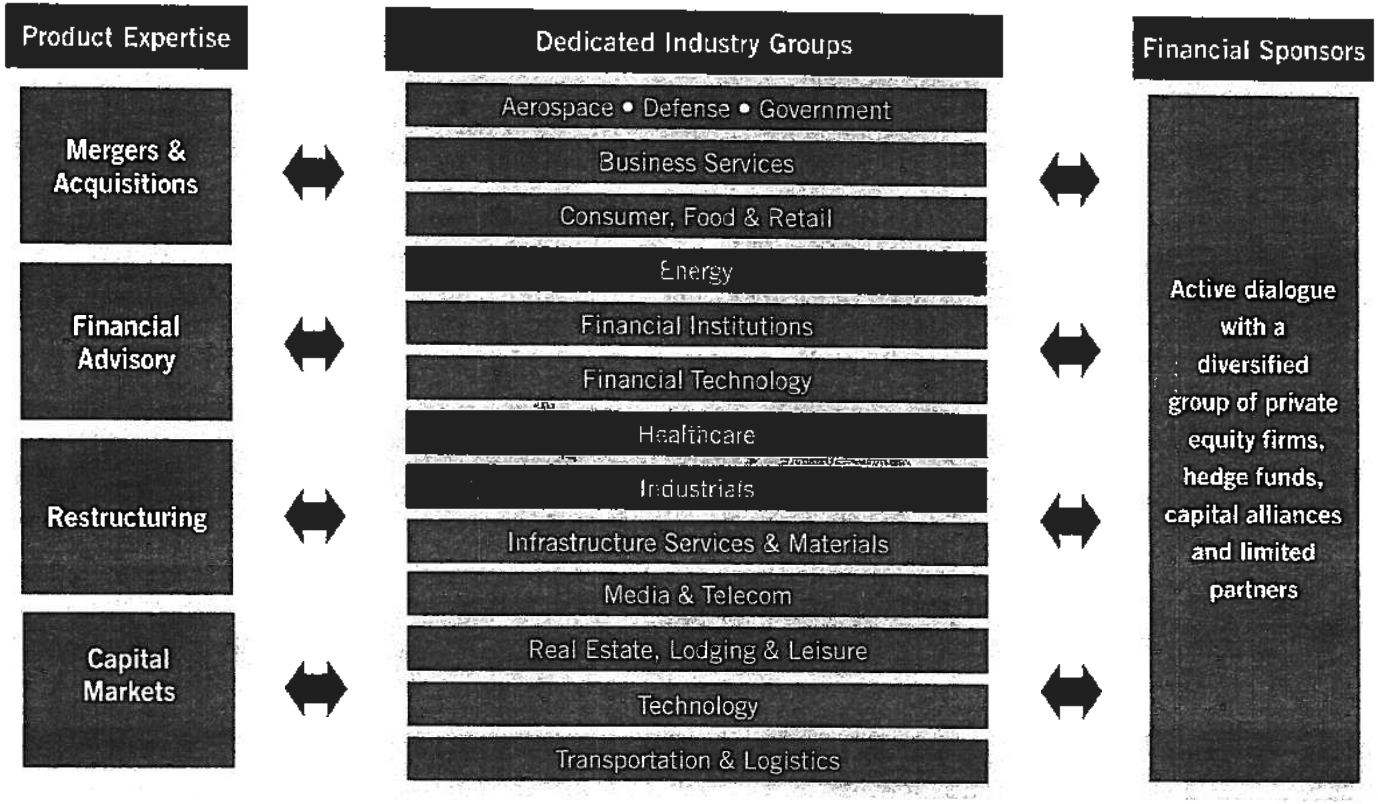
Fully Integrated Industry, Product and Private Equity Capabilities



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Strategic Global Presence

- Houlihan Lokey has over 800 employees in 14 offices worldwide
- With three offices in Europe and three offices in Asia, Houlihan Lokey has the global reach and local country presence to support international transactions
- In 2005, Houlihan Lokey partnered with ORIX Corporation (NYSE:IX), a leading integrated financial services group, headquartered in Tokyo, Japan
- In 2010, Houlihan Lokey expanded its presence into India and Singapore through a strategic minority investment in the Avista Advisory Group, a 25-person investment banking firm headquartered in Mumbai

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Fairness Opinion Services

Fairness Opinion Services

Uniquely Qualified

Experience

Attributes of Large Firm

- Global reach – presence in United States, Europe and Asia
- Dedicated industry groups and product specialists
- Credibility with and access to acquisition candidates
- Financing markets expertise – understanding of public and private financing alternatives

No. 1 M&A Fairness Opinion Advisor

M&A Fairness Advisory Rankings
Announced or Completed Deals – 2001 to 2010

Rank	Advisor	Number of Deals
1	Houlihan Lokey	642
2	JP Morgan	516
3	Bank of America Merrill Lynch	368
4	Morgan Stanley	323
5	UBS	304
6	Goldman Sachs & Co	287
7	Duff and Phelps	267
8	Credit Suisse	220
9	Citi	183
10	Somerley Ltd	181

Source: Thomson Reuters

Attributes of Mid-Size Firm

- Proven integrity – private advisory firm with no investment research, underwriting or equity positions
- Comprehensive guidance – creativity and analytical depth; routinely structure complex transactions and achieve compelling results
- Senior level attention – experienced, senior bankers lead all engagements

More Boards and Special Committees rely on Houlihan Lokey than any other advisor

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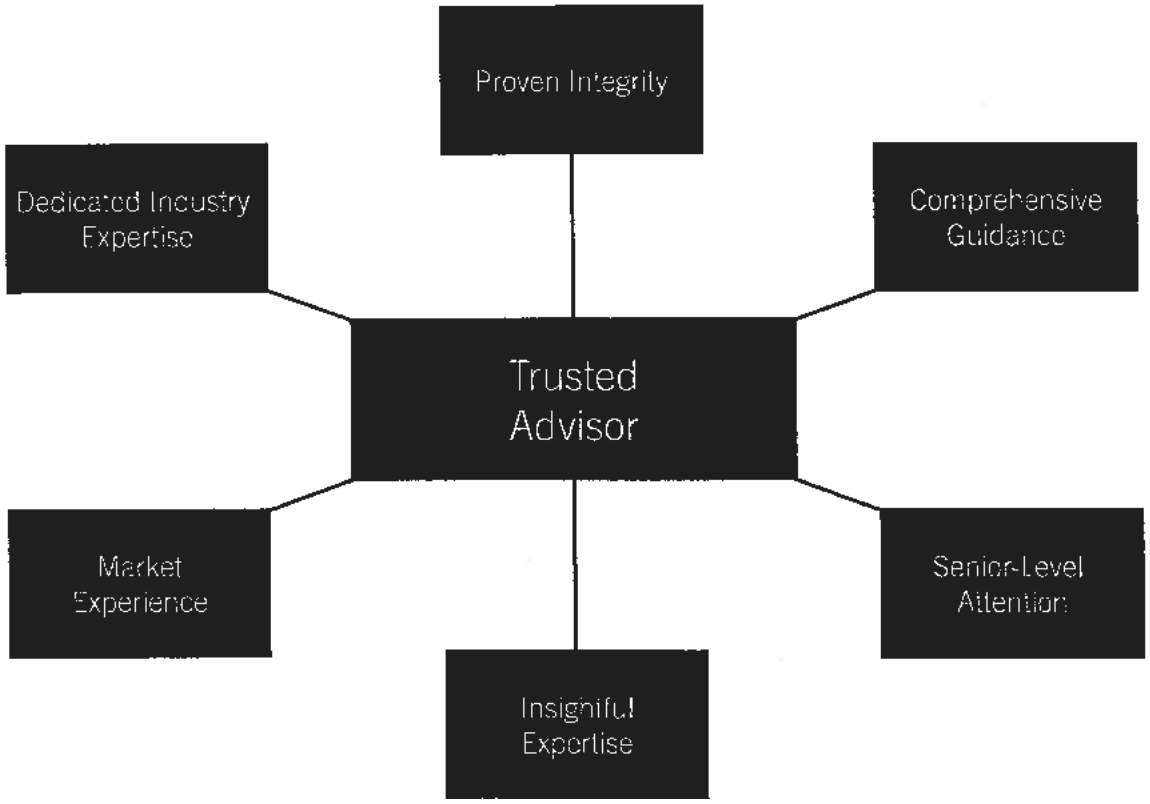
Fairness Opinion Services

Expert Advisors. Expert Opinions.



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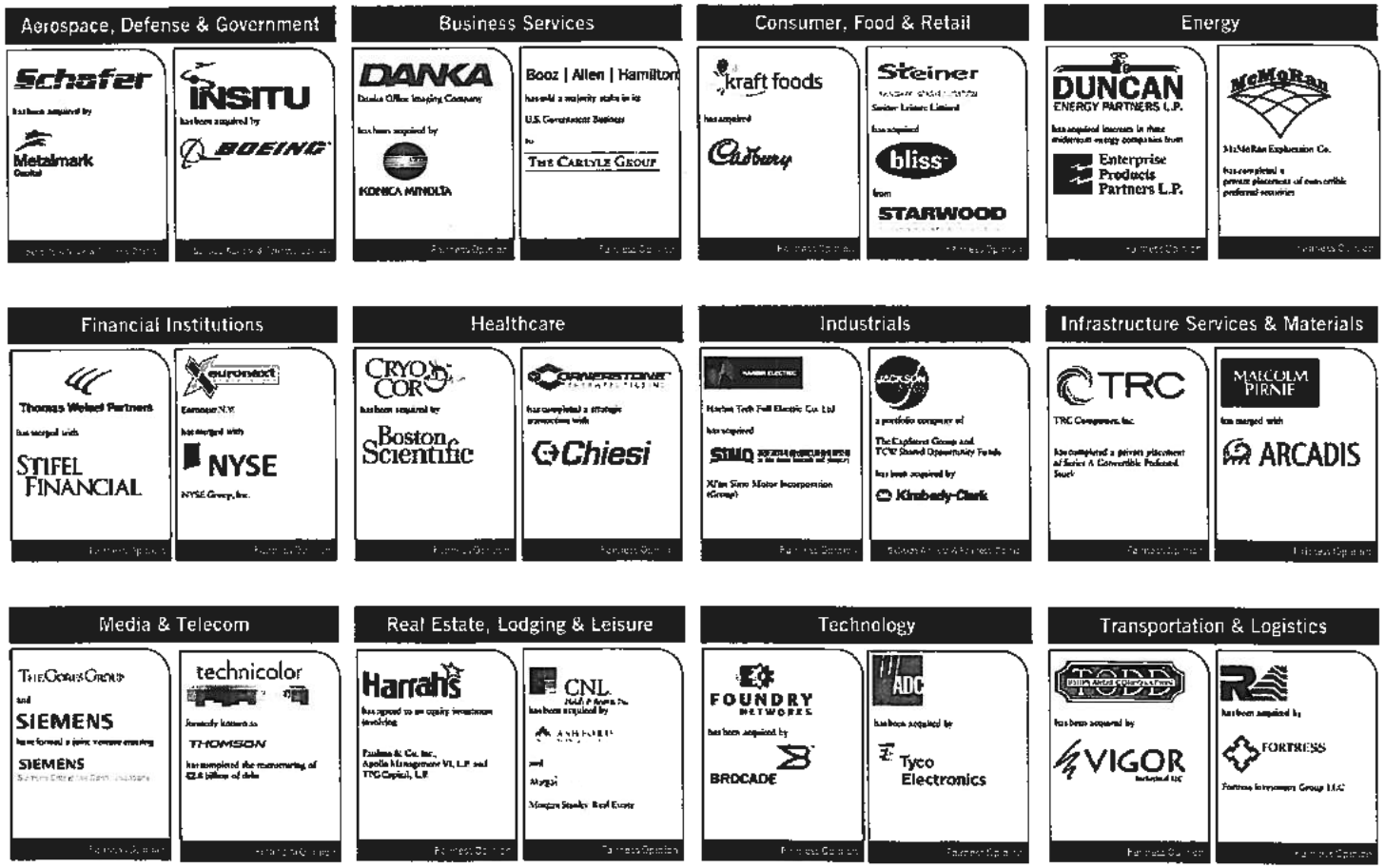
Fairness Opinion Services

Serving Companies Across a Broad Spectrum of Industries



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Fairness Opinion Services

Additional Selected Recent Fairness Opinion Engagements

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Fairness Opinion Services

Selected Recent Special Committee Fairness Opinions

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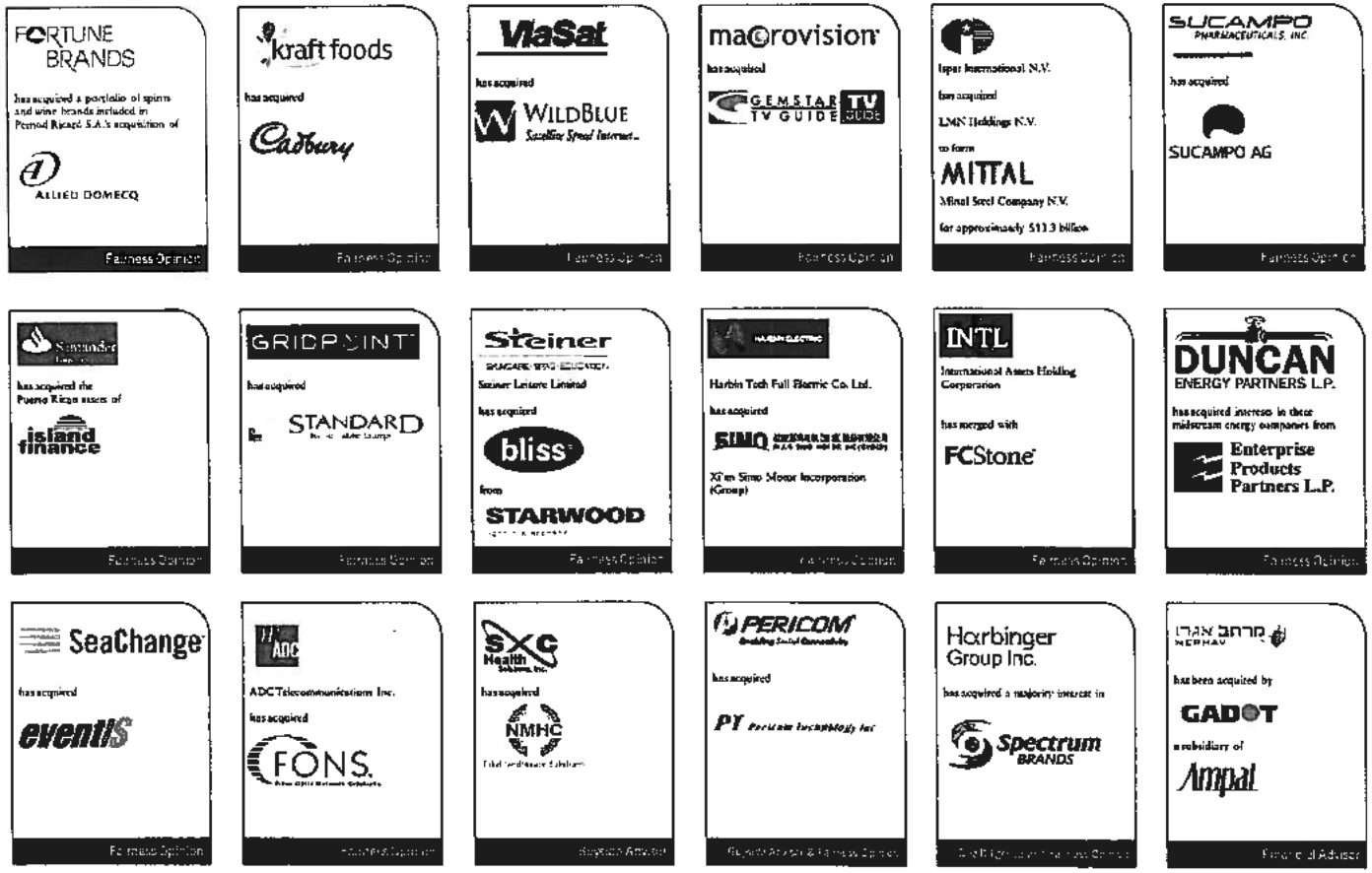
Fairness Opinion Services

Selected Recent Buyside Fairness Opinion Engagements



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Fairness Opinion Services

Selected "Second" Fairness Opinion Engagements

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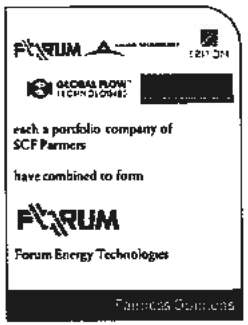
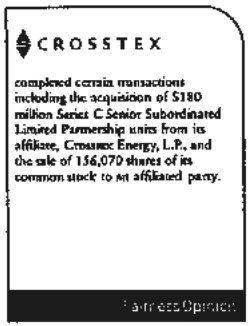
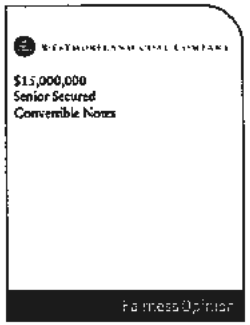
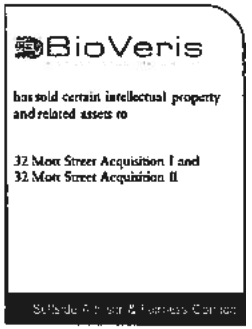
Fairness Opinion Services

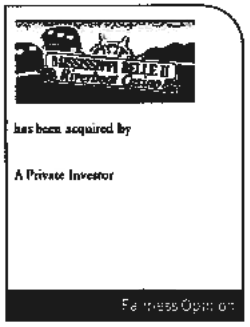
Selected Related Party Fairness Opinion Engagements

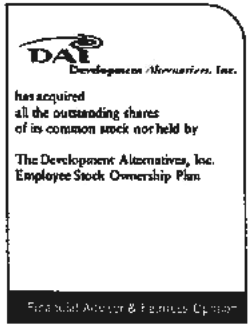


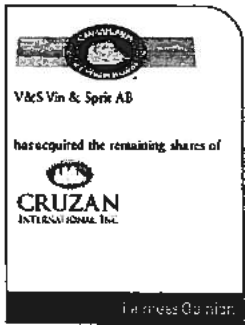












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Fairness Opinion Services

Selected 13e-3 Going Private Fairness Opinion Engagements

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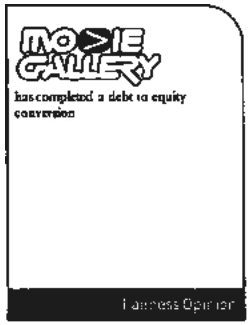
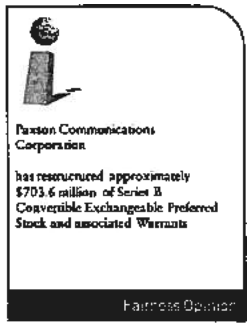
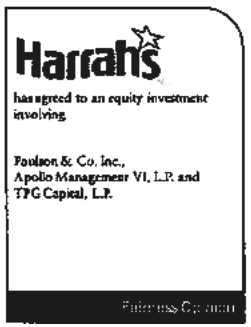
Fairness Opinion Services

Selected Exchange/Restructuring Fairness Opinion Engagements







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Overview of Houlihan Lokey / Healthcare Group

Overview of Houlihan Lokey / Healthcare Group

Leading Healthcare Investment Bank

Capabilities

- #1 advisor in U.S. sellside middle-market (<$1 billion) healthcare transactions over the last three years
- Extensive transaction experience - completed over 125 M&A, fairness opinion and restructuring transactions
- Dedicated M&A professionals exclusively covering the Healthcare Marketplace
- Long-term relationship driven approach toward clients and transactions

Market Leading Healthcare Advisor

No. 1 Healthcare Investment Banking Advisor
U.S. Sellside Transactions Under $1 Billion
2008-2010

Rank	Advisor	Number of Deals
1	Houlihan Lokey	31
2 *	Goldman Sachs & Co	27
2 *	Cain Brothers Co.	27
2 *	JP Morgan	27
5	Lazard	21
6	Piper Jaffray Cos	20
7	Bank of America Merrill Lynch	19
8 *	Jefferies & Co Inc	14
8 *	UBS	14
10	BC Ziegler	11

** denotes tie.*
Source: Thomson Reuters

2008 M&A Advisory Rankings
All U.S. Healthcare Transactions

Rank	Advisor	Number of Deals
1	Houlihan Lokey	19
2	JP Morgan	17
3 *	UBS	15
3 *	Goldman Sachs & Co	15
5 *	The Brafi Group	14
5 *	Morgan Stanley	14
7	Piper Jaffray Cos	13
8	Lazard	12
9 *	Credit Suisse	11
9 *	Merrill Lynch	11

** denotes tie.*
Source: Thomson Reuters

2007 M&A Advisory Rankings
U.S. Sellside Healthcare Deals Under $750 Million

Rank	Advisor	Number of Deals
1	Houlihan Lokey	12
2	UBS	11
3 *	Goldman Sachs & Co	9
3 *	William Blair & Co	9
5	JP Morgan	8
6	Wachovia Corp	7
7 *	Lazard	6
7 *	Morgan Stanley	6
7 *	Banc of America Securities LLC	6
10 *	Robert W Baird & Co Inc	5
10 *	Cain Brothers Co.	5
10 *	Jefferies & Co Inc	5

** denotes tie.*
Source: Thomson Financial

2008 M&A Advisory Rankings
U.S. Healthcare Deals Under $1 Billion

Rank	Advisor	Number of Deals
1	UBS	18
2	Houlihan Lokey	16
3	JP Morgan	14
4 *	Banc of America Securities LLC	12
4 *	Citigroup	12
6 *	Goldman Sachs & Co	10
6 *	Piper Jaffray Cos	10
8	Merrill Lynch & Co Inc	8
9 *	Duff and Phelps	7
9 *	Jefferies & Co Inc	7

** denotes tie.*
Source: Thomson Financial

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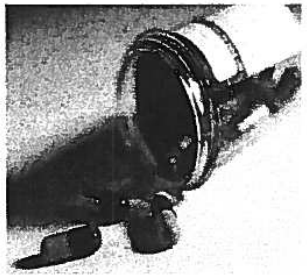
Overview of Houlihan Lokey / Healthcare Group

Extensive Experience in All Major Healthcare Sectors

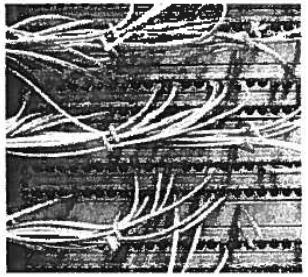
Healthcare Services

- Hospitals
- ASC / Specialty Hospitals
- Long-term Care
- Behavioral Health
- Diagnostic Imaging
- Distribution
- Home Nursing / Hospice
- Institutional Pharmacy
- Laboratories
- Outpatient Facilities
- Physician Services/PPMs/DPMs
- Rehabilitation
- Staffing



Med Tech / Life Sciences

- Medical Technology
  - Med Devices
  - Med Supplies
  - Capital Equipment
  - Diagnostics
- Pharmaceuticals
  - Contract Manufacturers
  - Sterile Production
  - Contract Sales
  - Drug Delivery
  - Generics
  - Specialty Pharma
- Biotechnology
  - Emerging
  - Large Cap



Healthcare Information Technology

- Software/Connectivity
- IT Outsourcing/ASP
- Clearing House
- Consulting and Data Analytics
- Web Portals
- Electronic Health Record
- Decision Support
- Electronic Prescribing
- Billing and Collections
- Coding

Managed Care

- Health Maintenance Organization
- Preferred Provider Organization
- Diversified
- Third Party Administrator
- Outsourced Service Provider

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Extensive Hospital Transaction Experience

- Houlihan Lokey is a leader in the hospital industry with selected clients that include:
  - Adventist Health Services
  - Allegheny Health Education and Research
  - Ardent Health Services
  - Arizona Heart Hospital
  - Avera McKennan Hospital
  - Baylor Healthcare System
  - Bossier Medical Center
  - Dayton Heart Hospital
  - Delaware Valley Medical Center
  - East Texas Medical Center
  - Forum Health
  - Fresno Heart Hospital
  - Glenwood Regional Medical Center
  - HCA
  - Health Management Associates
  - HealthSouth
  - Heart Hospital of Lafayette
  - Heart Hospital of South Dakota
  - Henry Mayo Newhall Memorial Hospital
  - Hillcrest Baptist Medical
  - Kansas Heart Hospital
  - LifePoint Hospitals
  - Louisiana Heart Hospital
  - MedCath
  - Oklahoma Heart Hospitals
  - Plymouth Health
  - Porter Memorial Hospital
  - Psychiatric Solutions
  - Rockdale Medical Center
  - Sequoia Hospital District
  - Saint Anthony's
  - Saint Vincent Catholic Medical Centers of New York
  - Selby General Hospital
  - Tenet Healthcare
  - Triad Hospital
  - Triumph HealthCare
  - Universal Health Services
  - Valley Baptist Medical Center
  - Vanguard Health Systems

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Not-For-Profit Experience

Houlihan Lokey has advised in a variety of not-for-profit situations including: sellside and buyside transactions, financings, stock valuations and restructurings. Additionally, we have advised state's attorney generals in their review of transactions and conversions. Notable engagements include:

- Serving as the investment banker to Forum Health leading the system's restructuring and sale processes while in Chapter 11
- Served as the financial advisor to the Official Committee of Unsecured Creditors and also served as the transaction broker to the National Benevolent Association for the sale of 11 owned senior care facilities
- Served as the financial advisor to the Official Unsecured Creditor's Committee of Allegheny Health Education and Research Foundation's ("AHERF") Philadelphia operations
  - In addition, Houlihan Lokey helped market and sell AHERF's Pittsburgh operations to The Healthcare Alliance of Western Pennsylvania
- Advised the Attorney General of New Mexico on the acquisition of BlueCross BlueShield of New Mexico by Health Care Service Corporation
- Served as the financial advisor to the Official Committee of Unsecured Creditors of Saint Vincent Catholic Medical Centers of New York
- Advised the Attorney General of California on:
  - The acquisition of Daniel Freeman Hospitals by Tenet Healthcare Corporation and
  - The fair market value of Watsonville Community Hospital
- Advised BlueCross BlueShield of Maine in connection with a planned conversion
- Other selected not-for-profit clients include:
  - Firelands Regional Medical Center
  - Glenwood Regional Medical Center
  - Oklahoma Heart Hospital
  - Rockdale Medical Center

00744

Overview of Houlihan Lokey / Healthcare Group

Select Transaction Experience

Hospitals & Outpatient Surgery:

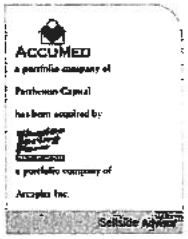
Long-Term Care Providers:

00745

Overview of Houlihan Lokey / Healthcare Group

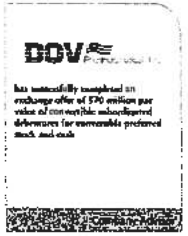
Select Transaction Experience (cont.)

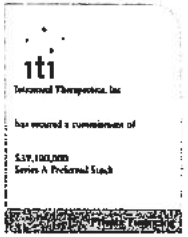
Home Care:



Rehab:

Life Sciences:





Specialty / Pharmacy Benefit Management:

Institutional & Retail Pharmacy:

00746

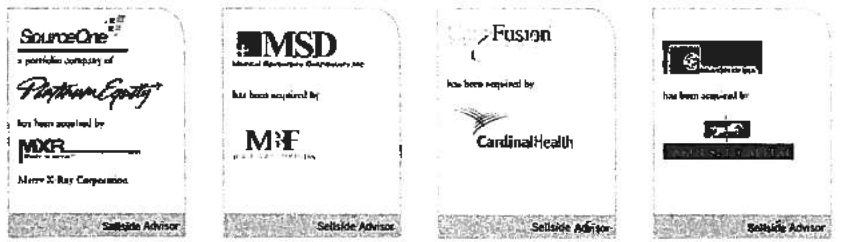
Overview of Houlihan Lokey / Healthcare Group

Select Transaction Experience (cont.)

Managed Care:

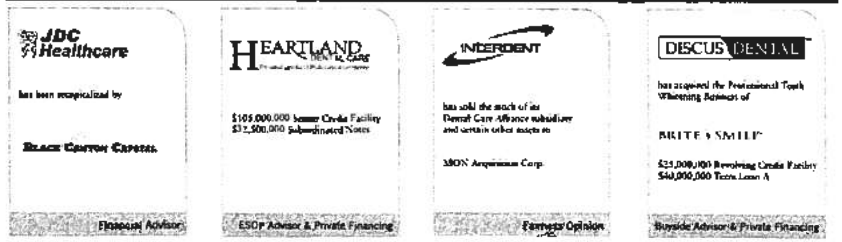
Disease Management / Wellness:

Distribution



Contract Manufacturing:

Dental:



00747

Overview of Houlihan Lokey / Healthcare Group

Select Transaction Experience (cont.)

Med Tech and Devices:

HCIT:

Clinical Lab / Diagnostic Screening Services:

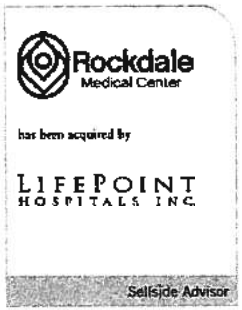
00748

Overview of Houlihan Lokey / Healthcare Group

Select Houlihan Healthcare Transaction Case Studies

Select Houlihan Healthcare Transaction Case Studies

Selected Houlihan Healthcare Case Study – Rockdale Medical Center, Inc.

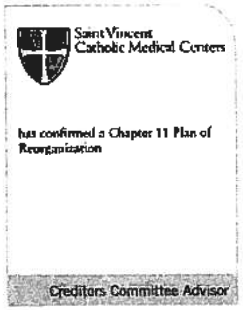


- ***Client Profile*** – Rockdale Medical Center ("RMC") is a JCAHO accredited 138 licensed bed, not-for-profit hospital that provides acute care, diagnostic services, emergency services and outpatient services throughout the local community. RMC is located in Conyers, Georgia, approximately 25 miles east of Atlanta and is the only hospital in Rockdale County. In 2002, RMC began a significant expansion and renovation project that caused the facility to borrow in excess of $90.0 million. As a result of this increased debt level, RMC began to experience significant difficulties in meeting its debt service, and ultimately went into covenant default. In accordance with the bond documents, RMC engaged several consulting firms to assist with performance improvement plans.
- ***Houlihan Lokey's Role*** – After being engaged as RMC's exclusive financial advisor, Houlihan Lokey conducted a comprehensive strategic review in conjunction with management and the board. We reviewed the following alternatives with the board: a physician syndication, a guarantee by the lead lender, a guarantee by the county, a joint venture and a sale of the hospital. After multiple avenues had been exhausted, it became apparent that the best option for the ongoing viability of the hospital and the provision of comprehensive healthcare services in Rockdale County was to sell the facility to a strategic party. As such, Houlihan Lokey conducted a comprehensive marketing process and negotiated the sale of RMC.
- ***Transaction Snapshot*** – Houlihan Lokey structured a sale of the assets to LifePoint Hospitals. Houlihan Lokey's highly competitive process resulted in LifePoint Hospitals emerging as the lead bidder with a premium purchase price, a commitment to fund a minimum of $30.0 million in future capital expenditures and favorable transaction terms.

00750

Select Houlihan Healthcare Transaction Case Studies

Selected Houlihan Healthcare Case Study – Saint Vincent Catholic Medical Centers of New York



- ***Client Profile*** – Saint Vincent Catholic Medical Centers ("SVCMC") is a comprehensive healthcare system which as of its July 5, 2005 bankruptcy filing employed over 2,500 physicians and in the calendar year prior to filing recorded more than 600,000 outpatient visits, 640,000 home care visits and 92,000 inpatient discharges. At filing, SVCMC operated seven hospitals located in four boroughs of New York City and in Westchester County. SVCMC also operated three nursing homes, a hospice, a home health business, a health maintenance organization and two captive insurance companies. SVCMC's flagship hospital was Saint Vincent Manhattan a 758-bed hospital located in Greenwich Village.
- ***Houlihan Lokey's Role*** – Houlihan Lokey served as financial advisor to the Official Committee of Unsecured Creditors in connection with SVCMC's Chapter 11 filing in the Southern District of New York.
- ***Transaction Snapshot*** – At the outset of the case the debtors suffered from a lack of liquidity and were struggling to close / monetize non-core assets. The Houlihan Lokey team immersed ourselves in many key initiatives to provide the direction and coordination that previously had been lacking and created critical alliances with the DOH, DASNY, HUD and the U.S. Trustee to ensure that creditors' interests were addressed and that SVCMC's operations were stabilized. Among the many issues in which Houlihan Lokey played a significant role working on behalf of creditors was obtaining permanent DIP financing, selection of interim senior management (CEO and CRO), closing non-core asset sales, assessing and implementing various real estate monetization options, selection of a real estate consultant given SVCMC's extensive real estate assets, testing and finalizing a long-term business plan and developing and negotiating alternative plan structures and methods of creditor repayment. Throughout the case Houlihan Lokey worked constructively with all constituents including the PBGC, the Tort Claimants' Committee, the Ad Hoc Committee of Secondary Claims Traders and SVCMC's management and advisors which helped facilitate a successful plan of reorganization which provides unsecured creditors with a 100% recovery.

00751

Houlihan Execution and Support Team Biographies

Ben A. Buettell

Mr. Buettell is a Managing Director in Houlihan Lokey's Chicago office and a senior member of the firm's Financial Advisory Services business. He serves as co-head of the firm's Fairness Opinion practice and is the head of the firm's Solvency Opinion practice.

Mr. Buettell has more than two decades of experience providing financial advisory services to public and private clients in connection with mergers, acquisitions, leveraged buyouts, spinoffs, recapitalizations, going-private transactions and strategic alternative assessments. He also renders fairness, solvency and transaction-related opinions to companies, boards of directors, special committees, financial institutions and independent fiduciaries.

Before joining Houlihan Lokey, Mr. Buettell worked for a Chicago-based financial institution as a commercial loan officer, serving privately held middle-market companies.

Mr. Buettell served on the board of directors of Euclid Beverage from August 2006 to August 2009. He also serves on the board of directors of the Boys and Girls Clubs of Chicago.

Mr. Buettell earned his B.A. in economics from Northwestern University and a master of management degree in finance and management policy from Northwestern University's Kellogg School of Management. He is registered with FINRA as a General Securities Principal (Series 7, 24 and 63) and a Limited Representative – Investment Banking (Series 79).

00753

Gary D. Brewster

Mr. Brewster is a Managing Director in Houlihan Lokey's New York office, where he is a member of the Financial Advisory Services business and the Healthcare Group. He has provided financial advisory services for mergers, acquisitions, joint ventures and alliances, strategic investments, and financings. He has also provided valuation opinions for private disputes and for regulatory agencies. He has served a number of healthcare industry sectors, including pharmaceutical, medical device, biotechnology, healthcare services, and information technology.

Before joining Houlihan Lokey, Mr. Brewster worked for Standard & Poor's, PricewaterhouseCoopers and IBM.

Mr. Brewster has spoken at numerous industry and technical conferences. He has been a long-time supporter of the educational programs of Inner City Scholarship Fund and Carnegie Hall.

Mr. Brewster received a B.S. in industrial engineering from Stanford University and earned his M.B.A. from the Wharton School. He is registered with FINRA as a General Securities Representative (Series 7 and 63) and a Limited Representative – Investment Banking (Series 79).

00754

Mark Francis

Mr. Francis is a Managing Director in Houlihan Lokey's Dallas office, where he is Co-Head of the Healthcare Group. He has nearly two decades of experience in mergers and acquisitions and financial operations in the healthcare industry, and he has managed a wide variety of projects, from acquisitions, divestitures, financings and financial restructurings to joint ventures and strategic-alliance formation.

Before joining Houlihan Lokey, Mr. Francis directed a national team of acquisition professionals as vice president of M&A for the home health division of HCA. He speaks frequently on mergers and acquisitions and finance in the healthcare industry.

Mr. Francis earned a B.B.A. in finance from Baylor University. He is a Certified Public Accountant and is registered with FINRA as a General Securities Principal (Series 7, 24 and 63) and a Limited Representative – Investment Banking (Series 79).

00755

Sam W. Clark

Mr. Clark is a Managing Director in Houlihan Lokey's Dallas office, where he heads the firm's Financial Advisory Services effort in the Southwest and is the global leader of the Tax and Financial

Reporting and Transaction Advisory Services practices. He has over 25 years of experience advising clients on mergers and acquisitions, valuations, financings, and assessing strategic alternatives in such industries as healthcare, technology, manufacturing, real estate and energy.

Before joining Houlihan Lokey, Mr. Clark was a managing director and the founder of Standard & Poor's Southwest Valuation practice, formerly the PricewaterhouseCoopers Southwest Regional Valuation practice. Before that, he was the managing director of PricewaterhouseCoopers Southwest Regional Valuation and Corporate Finance practice.

Mr. Clark earned a B.B.A. in finance from Texas A&M University and an M.B.A. in finance from the University of North Texas. He completed an executive development program at Northwestern University and valuation coursework at Harvard University. He is a Certified Public Accountant accredited in business valuation, a senior member of the American Society of Appraisers, a licensed real estate broker and a state-certified general real estate appraiser. He is registered with FINRA as a General Securities Representative (Series 7 and 63) and a Limited Representative – Investment Banking (Series 79).

00756

Michael DeLuke

Mr. DeLuke is a Director in Houlihan Lokey's Dallas office. He has more than a decade of professional services and valuation experience in the healthcare, financial services, manufacturing and energy industries.

Before joining Houlihan Lokey, Mr. DeLuke was a manager in PricewaterhouseCoopers' Standard & Poor's corporate value consulting practice, where his valuation assignments addressed acquisitions, divestitures, fairness opinions, corporate planning, purchase price allocations, and financial advisory. Earlier, he worked for several years at another accounting firm, performing business valuations and providing tax and audit services.

Mr. DeLuke has a B.B.A. in accounting from Baylor University, a master's degree in taxation from Baylor University, and an M.B.A. in finance from the University of Texas. He is a member of the American Institute of Certified Public Accountants and the Texas Society of Certified Public Accountants. He is also a member of the Financial Accounting Standard Board's Valuation Resource Group, which identifies and resolves fair-value measurement issues. He is registered with FINRA as a General Securities Representative (Series 7 and 63) and a Limited Representative – Investment Banking (Series 79).

00757

RESPONSE TO RFP

FOR

FAIRNESS EVALUATION FOR CONVERSION OF GREATER WATERBURY HEALTH NETWORK, INC.

SUBMITTED TO:
GREATER WATERBURY HEALTH NETWORK, INC.
ATTENTION: MS. DARLENE STROMSTAD, FACHE
PRESIDENT/CEO
64 ROBBINS STREET
WATERBURY, CONNECTICUT 06708

Principle Valuation, LLC

PEOPLE AND VALUES YOU CAN TRUST

October 13, 2011

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Attention: Ms. Darlene Stromstad, FACHE
President/CEO

Re: Fairness Evaluation for Conversion of Greater Waterbury Health Network, Inc.

This letter serves as our proposal to provide the Board of Directors of Greater Waterbury Heath Network, Inc ("Board", or "GWHN") a Fairness Evaluation in conjunction with its announced three-way joint venture (the "Transaction") with St. Mary's Health System, Inc. and LHP Hospital Group, Inc.

PURPOSE AND BACKGROUND

We understand that the purpose of our analysis will be to provide the Board a fairness evaluation of the Transaction in order for the Board to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 119a-486 et seq. ("Conversion Statute").

SCOPE

In determining whether the consideration is fair from a financial point of view, we will specifically address the following valuation issues and considerations:

- Assess the "Fair Market Value" of the assets to be transferred by GWHN
- Assess the intangible value to the Greater Waterbury community of maintaining the of GWHN
- Assess the value from a financial point of view of the commitment to build a replacement facility
- Assess from a financial point of view the value of the management agreement that the joint venture will enter into with an LHP affiliate to manage the hospital's operations

In conducting these assessments the following considerations will be made:

- Review the terms associated with the Transaction

- Conduct a site visit to the Hospital to accurately describe and assess the condition of the assets to be transferred
- Review the historical and earning potential of the operating assets that GWHN intends to transfer
- Review and analyze the terms associated with the Management Agreement to be entered into with an affiliate of LHP
- Review the plans, budgets, and financial projections associated with the replacement facility
- Consider the overall market potential of the Waterbury Hospital and the combined joint venture separately and as combined
- Review and analyze other pertinent and necessary information necessary to arrive at our final opinions
- Review and extrapolate transactions that involved for-profit versus non-for-profit organizations and academic hospital systems versus community hospital systems

Fair Market Value for the purposes of this analysis will be defined as follows:

> The most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

PRINCIPLE VALUATION FIRM OVERVIEW, RELEVANT EXPERIENCE, AND TEAM MEMBERS

In 2007, Timothy Baker and David Felsenthal combined their 75 years of healthcare appraisal experience to form Principle Valuation, a firm dedicated to service the specialized needs of the healthcare community. In 2009, Patrick Simers joined as a Principal in the firm and added to the strength of the overall hospital valuation core with more than 25 years in the appraisal of Healthcare properties. All of the Principals of Principle Valuation,("PV" and "Principle"), have served as Presidents and Vice Presidents of many of the major healthcare valuation and healthcare consulting providers including Huron Consulting, American Appraisal, CBIZ, and Valuation Counselors, a valuation firm that Mr. Felsenthal had previously founded which was once recognized as the premier healthcare valuation firm in the industry. From inception our staff has continued to expand and we now have more than seventeen professional employees dedicated to the valuation of healthcare related entities.

Our business is generally segmented into three primary sectors; Hospital and Healthcare Enterprise Related Services, Healthcare Advisory Services; and Senior Housing Related Services.

In the Hospital and Healthcare Related services group, the primary emphasis is to prepare valuations to meet the regulatory guidelines associated with hospital transactions including Stark compliance, State Regulatory Requirements and Purchase Accounting. Valuations conducted in this sector generally include the valuation of hospitals and hospital systems, medical practices, joint ventures valuations, service agreements and other types of healthcare business arrangements. Another major focus of this group is the valuation of tangible and intangible assets associated with purchase accounting for Acute and Specialty Hospitals. Professionals in this group have real estate, medical equipment, and business enterprise expertise.

The Healthcare Advisory Services group is primarily responsible for the preparation of cost segregation studies, facility live analysis, and asset inventory and reconciliation reports. This group's personnel consists of staff members with engineering and tax expertise that assist our clients in reducing their overall tax liability and developing accurate property records that help our clients increase their overall bond ratings. Our Senior Housing Group focuses on the service needs of the senior housing industry. This group prepares market studies and valuations of nursing homes and assisted living residences. Their work is generally presented for financing and utilized to obtain conventional financing and through the HUD 232 program. Professionals in this group include real estate professionals who have detailed knowledge of the regulatory rules and reimbursement policies that dictate the seniors housing industry.

Particularly relevant engagements include fairness reviews and appraisals presented to comply with the Attorney General requirements in Georgia, Mississippi, Louisiana, Florida, Pennsylvania, and New Jersey. Direct hospital transfer assessments included Banks-Jackson-Commerce Hospital in Georgia; Baptist Memorial Hospital – North Mississippi in Mississippi; Ville Platte Medical Center and West Carroll Memorial Hospital in Louisiana; South Shore Hospital in Miami, Florida; and UPMC in Pittsburgh, Pennsylvania. We also recently assessed a hospital management agreement for Meadowlands Hospital Medical Center in New Jersey.

The primary parties that will be active in this engagement include Tim Baker, Patrick Simers, John Leary, and Mary Jo Duffy. As demonstrated by their Qualifications, each member of the team has more than 25 years in the valuation of healthcare enterprises and includes individuals with General Appraiser State Certifications, CFA's, and CPA's. These qualifications are included in the Addenda of this proposal.

DUE DILIGENCE DATA REQUIREMENTS

The following information will be initially and primarily required in order to complete the assignment:

- A Central Contact that is familiar with the overall operations and contemplated transaction. This person will serve as our primary contact and should be able to discuss the financial, and market environment for the assets under consideration. Further this person should have the ability to coordinate site visits with our staff with the Hospital
- Audited Financial Statements of GWHN and its primary operating units for the past three years along with the current year-to-date operations and budgets.
- Forecasted operations for the next three-five year period for Waterbury Hospital operations
- A current Balance Sheet of the Organization and an explanation of which assets are anticipated to transfer
- A copy of the current fixed asset ledger of the Hospital and its associated entities in an excel format
- A listing of all real estate property anticipated to transfer with the transaction; including the address of the property, a brief description of the improvements including its size and use, its associated tax parcel number, and the size of the underlying land parcel
- A copy of any Board Minutes that discussed the contemplated Transaction
- A copy of any reports or presentations that Cain Brother's prepared in making its overall recommendations to the Board
- A copy of the Medicare Cost Reports for the prior two fiscal periods
- A non-redacted version of the CON Application that St. Mary's and LHP provided to the State
- The Current Plans, Budgets, and Forecasted Financials for the Replacement Facility
- A copy of the Management Agreement anticipated between GWHN and LHP
- A Contact at LHP that we can discuss their overall business operations, history, capital resources, financials, etc.
- The Management and Organizational Structure associated with the Joint Venture
- Any Demographic, Market Research, or Competitive Surveys that were conducted to support the overall merger
- A brief write-up of the subject's current ownership and operational history
- Any other data that you feel is necessary that enhances our understanding of the Transaction

PROCESS TIMELINE, LOGISTICS, AND COORDINATION

We would anticipate the following general time line which would lead to an overall engagement completion by November 30, 2011.

• First Week (Oct. 21)	Award of contract and receipt of data requested
• Second Week (Oct. 28)	In-house review of data received and prepare plan for on-site visit to be conducted in the third week
• Third Week (Nov. 4)	Conduct on site visit October 31-November 3 This will primarily consist of a time spent verifying asset lists and getting descriptive data on improvements
• Fourth Week (Nov. 11)	In-Office Pricing, Research, and Development of Preliminary Estimates
• Fifth Week (Nov. 17)	Presentation of Preliminary Findings and Draft Report Development
• Sixth Week (Nov. 25)	Client Review of Draft Report (Thanksgiving Week)
• Seventh Week (Nov. 30)	Adjustments and Development of Final Report

We believe that this time line is reasonable based upon the overall effort and personnel that would be involved in this analysis. Should a tighter time frame be needed, we may be able to accommodate. All time estimates assume that all data requests are promptly received on an ongoing basis throughout the engagement process. We would immediately notify you should any delays in the receipt of information or other items beyond our control would push back these delivery timelines.

CONFIRMATION OF ABSENCE OF ANY CONFLICTS OF INTEREST

Neither Principle Valuation nor its staff members have any known conflict of interest with the parties to this Transaction or to the Transaction itself.

COMPENSATION STRUCTURE

Our fee for this engagement will be [redacted] inclusive of all expenses. We ask that a retainer of [redacted] be issued upon acceptance of this letter. We will subsequently bill [redacted] upon presentation of our initial findings and draft report. We anticipate all payments to be current prior to issuing our final report. Our final invoice, [redacted] will accompany our final report; or if no final report is desired, upon your indication that no final report is required. Our fee is in no way contingent upon the outcome of our conclusions. This fee is based on our estimate of professional services to be furnished, according to our understanding of your requirements; should the scope of these requirements change, Principle Valuation and Greater Waterbury Health Network, Inc. will mutually revise the fee to reflect those changes in services.

Fees include professional time for planning and executing the work through, and including, our final report. Should you require additional consultation based on your reviews of our work or those of your external auditors or your tax or other advisors, or any public presentation, testimony and appearance in front of any tribunal, agency or other body, subsequent payment will be required and we will bill for those services at our prevailing hourly rate for the personnel involved.

We reserve the right to withhold delivery of our preliminary conclusions or final report(s) if, when either of these is ready for delivery, any previously issued invoice remains unpaid. We reserve the right to issue interim or final invoices, as appropriate, should you delay the project and/or in the event that our preliminary or draft report has been in your possession for more than 30 days.

You have the right to terminate this assignment at any time, in which case there will be no further obligation on the part of either party to continue. In such event, you will be obligated to pay only for the actual time and charges accumulated through the date of cessation.

GWHN agrees to indemnify and hold harmless Principle Valuation, its employees, and representatives, collectively ("Principle") from and against any and all losses, claims, damages, or liabilities, joint or several, including all reasonable out-of-pocket expenses, fees, and disbursements of counsel incurred by Principle in defending any claim, action, or proceeding whether or not resulting in a liability to Principle to which they may become subject, caused by, arising out of or in connection with this engagement, including but not limited to, losses, claims, damages or liabilities caused by or arising out of any untrue statements of material fact contained in the information provided to Principle by GWHN or its advisors in connection with our engagement, or any omission to state any therein any material fact required or necessary to make the information not misleading in light of circumstances under which given, or any violation of the federal securities laws or the securities laws of any state, or otherwise arising out of our engagement hereunder except in respect to any matter as to which Principle shall have been adjudicated to have acted with gross negligence or willful malfeasance.

ACKNOWLEDGEMENT

We appreciate this opportunity to provide our recommendations for valuation-consulting services. We are uniquely qualified to perform this assignment, by virtue of our independence, experience, reputation, and expertise. We are committed to completing the work in an efficient and timely manner.

Due to the complexity of the assignment; if any of the terms, as highlighted, need to be discussed or refined please do not hesitate to call us as we would appreciate the opportunity to work with you on this important assignment.
But, if the content of this document correctly reflects your understanding of our agreement, please sign below and return the executed document and return the enclosed copy. This agreement shall remain open and valid for signature for 90 days from the issue date; however, any significant delay in executing this agreement could adversely impact our ability to meet the delivery commitments described herein. Please note we will be unable to start this engagement until we are in receipt of this signed acknowledgment. To avoid any delays in delivery, please

fax the signed acknowledgment to (312) 422-1515. Thereafter, please forward the original to us.

If you have any questions or comments, please call me at (770) 924-8811.

Respectfully submitted,

PRINCIPLE VALUATION, LLC

Patrick J. Simers
PJS/ms

CLIENT: GREATER WATERBURY HEALTH NETWORK, INC.

SIGNATURE(S): _____

NAME (PRINT OR TYPE): _____

TITLE: _____

DATE: _____

PHONE: _____

EXHIBITS

TIMOTHY H. BAKER
PRESIDENT

EXPERIENCE

Mr. Baker has been in the appraisal industry since 1981 with a concentration on healthcare and senior living properties. His valuation experience includes valuing the business enterprise, real estate, and personal property. Valuations have been performed on a national and international basis. Consulting engagements include market and financial feasibility studies.

Mr. Baker has experience in the valuation of numerous healthcare facilities including acute care, behavioral health, and rehabilitation hospitals. Senior living properties include nursing homes, assisted living facilities, and retirement centers. Other related operations include research facilities, healthcare leasing companies, physician practices, and medical office buildings. Mr. Baker has also provided consultations on market assessment, demand analysis, reimbursement issues, development of fixed asset records, and provided analysis of strategic opportunities. Valuation reports prepared by Mr. Baker have been used for several purposes including public offerings, litigation support, HUD 232 and 242 mortgage insurance programs, acquisition/divestitures, property tax purposes, state reimbursement, estate planning, and for internal management decision making.

PROFESSIONAL HISTORY

- 2007 to present – President, Principle Valuation, LLC.
- 2001 to 2007 - Senior Vice President, Wellspring Valuation, Ltd.
- 1997 to 2001 - Vice President, Marshall & Stevens National Healthcare Practice.
- 1992 to 1997 - Senior Manager, Capital Valuation Group, specializing in the valuation of the business and real estate of senior living and healthcare related facilities.
- 1981 to 1992 – Manager, Valuation Counselors where he was responsible for performing a multitude of appraisal and consulting services for clients specializing in business enterprise, real estate, and machinery and equipment.

PROFESSIONAL AFFILIATIONS

- Advisory Committee Member American Senior Housing Association
- Healthcare Financial Management Association
- American Health Lawyers Association
- Associate Member Appraisal Institute

EDUCATION LICENSES, AND DESIGNATIONS

- 1980 graduate of Bucknell University with a Bachelor of Science in Business Administration
- Certified General Real Estate Appraiser Maryland and New Jersey

TESTIMONY

- Testified as expert witness in California, Colorado, Connecticut, New Hampshire, New Jersey and Pennsylvania

PATRICK J. SIMERS
EXECUTIVE VICE PRESIDENT

EXPERIENCE

Mr. Simers has extensive experience in serving the valuation needs of the health-care industry. He has valued all tangible and intangible assets associated with health-care enterprises, including the capital stock of majority and minority share holdings; medical specialty and physician joint ventures; fee simple, leased fee, and leasehold interests in real estate for hospital systems, stand-alone hospital campuses, and medical office buildings; major and minor movable equipment; certificates of need; contractual agreements; and preferred provider arrangements.

Specific healthcare enterprises appraised include acute care hospital facilities, LTACH hospitals, psychiatric hospitals, rehab hospital facilities, single physician practices, multi-specialty practices, cath labs, diagnostic centers, cardiac care practices, home health agencies, nursing homes, assisted living facilities, and medical office buildings.

Mr. Simers has performed fair market value studies for purchase, sale, or financing; merger and acquisition consulting; negotiation of purchase price; fairness opinions; purchase price allocations; financial reporting; SEC reporting; Medicare regulatory requirements; Safe Harbor requirements; and 501(c)(3) private placement offerings.

PROFESSIONAL HISTORY

Mr. Simers began his appraisal career with Valuation Counselors in 1982 and held various consulting, business development, and management roles, including four years as president of Valuation Counselors, leading up to its merger with CBIZ Inc. Most recently, Mr. Simers has served as the National Director for Healthcare services for American Appraisal Associates where he spear-headed the development of healthcare services for this international appraisal firm.

Patrick J. Simers is Executive Vice President for Principle Valuation. He is responsible for the development and overall business plan for Principle's consulting and appraisal services to for-profit, nonprofit, and public health-care providers. Mr. Simers is located in Principle Valuation's Atlanta office.

PROFESSIONAL AFFILIATIONS

- American Health Lawyers Association
- Healthcare Financial Management Association

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Northern Illinois University with a Bachelor of Science in Finance and Economics
- Graduate of Moraine Valley College with a Associate in Arts in Business Administration
- Certified General Real Estate Appraiser in Georgia

JOHN L. LEARY, CFA

EXPERIENCE

Mr. Leary's hospital transaction experience consists of valuations for hospital acquisition and financing transactions in excess of $1 billion, SFAS 144 impairment studies for acute care hospitals, valuations for relative contributions of hospital operations to newly organized joint ventures, and valuations of certificate of need for new hospital construction.

His ambulatory surgery and diagnostic imaging center experience consists of valuation of surgery centers for hospital physician syndications, initial capitalization of joint venture between major metropolitan medical center and physician owned outpatient surgery center, and recapitalization of a multi-modality diagnostic imaging center owned by a partnership consisting of two medical centers and a radiology group.

Mr. Leary also has managed care experience that consists of an equity valuation of Medicaid Provider Service Network serving 50,000 Medicaid members, a SFAS 141 valuation of tangible and intangible assets for a managed care organization with a market capitalization of approximately $1.3 billion, and a purchase price allocation specialty pharmacy and pharmacy benefit management company totaling $1.5 billion.

Mr. Leary has also performed valuations of dialysis, home health, durable medical equipment, respiratory and infusion therapy operations, and physician practices

PROFESSIONAL HISTORY

- 1989 to 2011 - CBIZ Valuation Group, LLC — Atlanta, GA
  Southeastern Director of Financial Valuation Services
- 1987 – 1989 - Carnegie Securities Corporation — Atlanta, GA
  Vice President
- 1980 – 1987 - Storer Cable Communications — Atlanta, GA
  Regional Controller

EDUCATION AND ACCREDITATIONS

- 1978 – 1980 - Georgia State University — Atlanta, GA
  Masters of Business Administration with a concentration in finance
- 1974 – 1978 - Emory University — Atlanta, GA
  Bachelor of Arts with majors in Economics and Political Science
- Chartered Financial Analyst and Certified Public Accountant (inactive license)

MARY JO DUFFY

EXPERIENCE

Ms. Duffy brings 25 years of accounting, auditing, business valuation, business consulting and financial management to her clients. She has testified as an expert witness in deposition and trial, and advised clients on strategy, transactions and general business issues in addition to valuation issues

Ms. Duffy began her career with KPMG as an accountant and auditor. As CEO of Valuation Counselors, a national valuation firm, she provided valuation services to entities as diverse as boat manufacturers, grocery chains, technology ventures and healthcare providers. She served as a partner in a national CPA firm, responsible for appraisal and valuation services nationwide and was a member of the firm's Management Council.

As National Director of Financial Services to the healthcare industry for Coopers & Lybrand L.L.P., a predecessor firm of PricewaterhouseCoopers, Ms. Duffy was responsible for litigation, valuation, merger & acquisition, reorganization and other services to healthcare entities and assisted healthcare clients with matters involving providers, payers and related organizations. She later joined Ernst & Young's Healthcare Consulting practice specializing in physician networks, operations improvement, M&A strategy and post-merger integration. Her expertise in the healthcare arena includes advising providers on strategic options, negotiating transactions and assisting a Debtor in Possession in disposing of the assets, preparing a physician organization for doubling in size and an IPO, and developing integrated networks in academic medical centers and community delivery systems. She has also been the CFO of multi-specialty, multi-site healthcare provider.

PROFESSIONAL HISTORY

- Director, Acultas, Inc.
- National Director of Financial Services, Coopers & Lybrand
- CEO, Valuation Counselors
- Consultant, Ernst & Young Healthcare Consulting
- Certified Public Accountant and Auditor, KPMG.

PROFESSIONAL AFFILIATIONS

- Leadership Team Member Healthcare Task Force of GSCPAS
- Serves as Board Member for: Turning Point Women's Healthcare, The Childhood Autism Foundation and Emory Austin Resource Center
- Member, Illinois CPA Society
- Officer, Georgia Society of CPAS – Atlanta Chapter

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Georgetown University School of Business
- Certified Public Accountant

HONORABLE DESIGNATIONS

- Honored by Atlanta Magazine as one of Atlanta's outstanding business women.

HEALTHCARE SYSTEMS AND HOSPITALS
OUR PROFESSIONALS HAVE SERVICED SINCE 2000

HEALTHCARE SYSTEMS:	CITY	ST
Advocate Health Care	Oak Brook	IL
Ascension Health	St. Louis	MO
Aurora Health Care	Milwaukee	WI
Banner Health Systems	Phoenix	AZ
Baptist Health South Florida	Coral Gables	FL
Baylor Health Care System	Dallas	TX
Benefis Health System	Great Falls	MT
Capella Healthcare	Franklin	TN
Catholic Health East	Newtown Square	PA
Centura Health	Englewood	CO
CHRISTUS Health	Irving	TX
Community Health Systems, Inc.	Brentwood	TN
Community Memorial Health System	Ventura	CA
Daughters of Charity Health System	Los Altos Hills	CA
Elmhurst Memorial Healthcare	Elmhurst	IL
Envision Corp.	Scottsdale	AZ
Essent Healthcare Inc.	Nashville	TN
Gulf States Health Services	Baton Rouge	LA
Health Care REIT, Inc.	Toledo	OH
Health East	Minneapolis	MN
Health Management Associates	Naples	FL
Holistic Health Care, Inc.	Birmingham	AL
Hospital Sisters Health System	Springfield	IL
Ingalls Health System	Harvey	IL
Jewish Hospital & St. Mary's Healthcare	Louisville	KY
Landmark Hospitals	Cape Girardeau	MO
LifeCare Management Service	Plano	TX
LifePoint Hospitals, Inc.	Brentwood	TN
Memorial Healthcare System	Hollywood	FL
NorthShore University Health System	Evanston	IL
Presbyterian Healthcare Services	Albuquerque	NM
Provena Health	Chicago	IL
Rapid City Regional Hospital	Rapid City	SD
Renaissance Healthcare Systems	Houston	TX
Resurrection Health Care	Chicago	IL
Saint Barnabas Health System	Livingston	NJ

HEALTHCARE SYSTEMS:	CITY	ST
Saint Thomas Health Services	Nashville	TN
Sarasota Memorial Healthcare System	Sarasota	FL
Seton Family of Hospitals	Austin	TX
Sisters of St. Francis Health Services	Mishawaka	IN
Specialty Hospitals of America, LLC	Portsmouth	NH
SSM Regional Health Services/St Mary's Health Center	Jefferson City	MO
St. Anthony Memorial Health Centers	Michigan City	IN
St. Francis Health System	Pittsburgh	PA
St. Vincent's Health System	Birmingham	AL
Summa Health Systems	Akron	OH
Trinity Health	Novi	MI
Universal Health Services	King of Prussia	PA
University Hospital Health System - Cleveland	Cleveland	OH
University Hospital Health System - San Antonio	San Antonio	TX
Vanguard Health Systems	Nashville	TN
Vibra Healthcare	Mechanicsburg	PA

HOSPITALS:	CITY	ST
Carraway Burdick West Medical Center	Haleyville	AL
Carraway Northwest Medical Center	Winfield	AL
Crestwood Medical Center	Huntsville	AL
Hartselle Medical Center	Hartselle	AL
Parkway Medical Center	Decatur	AL
Russellville Hospital	Russellville	AL
Southern Cancer Center	Mobile	AL
Harris Hospital	Newport	AR
Helena Regional Medical Center	Helena	AR
National Park Medical Center	Hot Springs	AR
North Metro Medical Center	Jacksonville	AR
Siloam Springs Memorial Hospital	Siloam Springs	AR
St. Mary's Regional Medical Center	Russellville	AR
Holy Cross Hospital	Nogales	AZ
Plaza del Rio Campus	Sun City	AZ
St. Joseph Hospital	Tucson	AZ
St. Mary's Hospital	Tucson	AZ
Sun Health Del E. Webb Campus	Sun City West	AZ
Tuscan Medical Center	Tucson	AZ
William O. Boswell Hospital	Sun City	AZ
Cedars Sinai Medical Center	Los Angeles	CA

HOSPITALS:	CITY	ST
Community Hospital of the Monterey Peninsula	Monterey	CA
Downey Regional Medical Center	Downey	CA
Hemet Valley Medical Center	Hemet	CA
Hollywood Presbyterian Medical Center	Los Angeles	CA
Kentfield Rehabilitation & Specialty Hospital	Kentfield	CA
Lancaster General Hospital	Lancaster	CA
Menifee Valley Medical Center	Sun City	CA
Norris Comprehensive Cancer Center & Hospital	Los Angeles	CA
Parkview Community Hospital	Riverside	CA
Physicians' Hospital of Rancho California	Murrieta	CA
Robert H. Ballard Rehabilitation Hospital	San Bernardino	CA
San Joaquin Valley Rehabilitation Hospital	Fresno	CA
USC University Hospital	Los Angeles	CA
Ventura Hospital	Ventura	CA
Lutheran Campus ASC LLC	Wheat Ridge	CO
OrthoColorado Hospital	Lakewood	CO
Penrose Hospital	Colorado Springs	CO
St. Anthony North Hospital	Westminster	CO
St. Mary-Corwin Medical Center	Pueblo	CO
St. Thomas More Hospital	Canon City	CO
Capital Hills Hospital	Sharon	CT
Greenwich Hospital	Greenwich	CT
Sharon Hospital	Sharon	CT
Greater Southeast Community Hospital	Washington	DC
Providence Hospital	Washington	DC
Specialty Hospital of Washington-Hadley	Washington	DC
Boca Raton Community Hospital	Miami	FL
Baptist Hospitals of Miami	Miami	FL
Bonita Community Health Center	Boca Raton	FL
East Point Hospital	Bonita Springs	FL
Fishermen's Hospital	Marathon	FL
Health Central Hospital	Ocoee	FL
HealthSouth Ridgelake Hospital	Sarasota	FL
Holy Cross Hospital	Marathon	FL
Homestead Hospital	Fort Lauderdale	FL
Jacksonville Medical Center	Homestead	FL
Mercy Hospital	Miami	FL
Memorial Hospital Pembroke	Jacksonville	FL
Memorial Hospital of South Broward	Pembroke Pines	FL

HOSPITALS:	CITY	ST
Memorial Regional Hospital	Hollywood	FL
Northwest Florida Community Hospital	Chipley	FL
Park Royal Hospital	Ft. Myers	FL
Santa Rosa Medical Center	Milton	FL
Shands Lake Shore	Lake City	FL
Shands Live Oak	Live Oak	FL
Shands Starke	Starke	FL
West Kendell Baptist Hospital	Kendell	FL
Wuesthoff Medical Center-Rockledge	Rockledge	FL
Wuesthoff Medical Center-Melbourne	Melbourne	FL
Athens Long-Term Acute Care Hospital	Athens	GA
Banks-Jackson-Commerce Hospital and Nursing Home	Atlanta	GA
Grady Memorial Hospital	Atlanta	GA
Hamilton Medical Center	Dalton	GA
Complex Care Hospital of Idaho	Meridian	ID
Advocate Bethany Hospital	Chicago	IL
Advocate BroMenn Regional Medical Center	Normal	IL
Advocate Christ Medical Center	Oak Lawn	IL
Advocate Condell Medical Center	Libertyville	IL
Advocate Good Samaritan Center	Downers Grove	IL
Advocate Illinois Masonic Medical Center	Chicago	IL
Advocate Lutheran General Hospital	Park Ridge	IL
Advocate South Suburban Hospital	Hazel Crest	IL
Elmhurst Memorial Hospital	Elmhurst	IL
Evanston Northwestern Health Care	Evanston	IL
Good Shepherd Hospital	Barrington	IL
Gottlieb Memorial Hospital	Melrose Park	IL
Holy Family Medical Center	Des Plaines	IL
Marshall Browning Hospital	DuQuoin	IL
Mercy Hospital & Medical Center	Chicago	IL
Northwest Community Hospital	Arlington Heights	IL
Our Lady of Resurrection Medical Center	Chicago	IL
Palos Community Hospital	Palos Heights	IL
Provena St. Joseph Hospital	Elgin	IL
Provena St. Mary Hospital	Aurora	IL
Resurrection Medical Center	Chicago	IL
Rockford Memorial Hospital	Rockford	IL
Rush-Copley Medical Center	Aurora	IL
Rush University Medical Center	Chicago	IL

HOSPITALS:	CITY	ST
Saint Anthony Hospital	Chicago	IL
Saint Joseph's Medical Center	Joliet	IL
Sherman Hospital	Elgin	IL
St. Anthony's Memorial Hospital	Effingham	IL
St. Elizabeth Hospital	Chicago	IL
St. Elizabeth Medical Center	Granite City	IL
St. Francis Hospital	Evanston	IL
St. James Hospital & Health Center	Chicago Heights	IL
St. John's Hospital	Springfield	IL
St. Joseph Hospital	Chicago	IL
St. Mary's Hospital	Decatur	IL
St. Mary's Hospital	Kankakee	IL
St. Mary's Hospital	Streator	IL
St. Mary of Nazareth Hospital	Chicago	IL
Swedish American Hospital	Rockford	IL
The Hospital for Specialty Care	Chicago	IL
Bluffton Regional Medical Center	Bluffton	IN
Dukes Memorial Hospital	Peru	IN
DuPont Hospital	Fort Wayne	IN
Elkhart General Hospital	Elkhart	IN
Franciscan Point Saint Anthony Health Complex	Crown Point	IN
Franciscan Physician Hospital	Munster	IN
Heartland Memorial Hospital	Munster	IN
Kosciusko Community Hospital	Warsaw	IN
Lutheran Hospital of Indiana	Fort Wayne	IN
Monroe Hospital	Bloomington	IN
Morgan Hospital and Medical Center	Martinsville	IN
OP Pavilion	Dyer	IN
Pinnacle Hospital	Crown Point	IN
Pulaski Memorial Hospital	Winamac	IN
Rehabilitation Hospital of Fort Wayne	Fort Wayne	IN
Starke Memorial Hospital	Knox	IN
St. Anthony Memorial	Michigan City	IN
St. Francis Hospital - Mooresville	Mooresville	IN
St. Francis Hospitals & Health Centers - South Campus	Indianapolis	IN
St. Joseph Hospital	Fort Wayne	IN
St. Joseph Regional Medical Center	Mishawaka	IN
St. Margaret Mercy Hospital	Hammond	IN
St. Vincent Indianapolis Hospital	Indianapolis	IN

HOSPITALS:	CITY	ST
Shawnee Mission Medical Center	Shawnee Mission	KS
Western Plaines Medical Complex	Dodge City	KS
Jewish Hospital	Louisville	KY
Jewish Hospital Shelbyville	Shelbyville	KY
Southern Kentucky Rehabilitation Hospital	Bowling Green	KY
Avoyelles Hospital	Marksville	LA
Baton Rouge General Medical Center	Baton Rouge	LA
CHRISTUS Coushatta Health Care Center	Coushatta	LA
CHRISTUS Schumpert Highland	Shreveport	LA
CHRISTUS Schumpert St. Mary Place	Shreveport	LA
CHRISTUS St. Francis Cabrini Hospital	Alexandria	LA
CHRISTUS St. Patrick Hospital	Lake Charles	LA
HealthSouth Specialty Hospital of North Louisiana	Ruston	LA
Oakdale Community Hospital	Oakdale	LA
Presbyterian Intercommunity Hospital	Lafayette	LA
River West Medical Center	Plaquemine	LA
Sabine Medical Center	Many	LA
Merrimack Valley Hospital	Haverhill	MA
New Bedford Rehabilitation Hospital	New Bedford	MA
Hillsdale Community Health Center	Hillsdale	MI
St. Joseph Mercy Hospital	Ypsilanti	MI
Truvista Surgery Center	Troy	MI
St. Joseph's Hospital	St. Paul	MN
Cape Girardeau Long-Term Acute Care Hospital	Cape Girardeau	MO
Crossroads Regional Hospital	Wentzville	MO
Franciscan Sisters of Our Lady of Perpetual Help of Ohio	St. Louis	MO
Joplin Long-Term Acute Care Hospital	Joplin	MO
Mineral Area Regional Medical Center	Farmington	MO
Northcrest Regional Medical Center	Kirksville	MO
North Kansas City Hospital	North Kansas City	MO
SSM Regional Health Services	Jefferson City	MO
St. Alexius Hospital - Broadway Campus	St. Louis	MO
St. Alexius Hospital - Jefferson Campus	St. Louis	MO
St. Anthony's Medical Center	St. Louis	MO
St. Mary's Health Center	Jefferson City	MO
St. Mary's Hospital of Blue Springs	Blue Springs	MO
Oxford Lafayette Medical Center	Oxford	MS
Marlton Rehabilitation Hospital	Marlton	NJ
Meadowlands Hospital Medical Center	Secaucus	NJ

HOSPITALS:	CITY	ST
Memorial Hospital of Salem County	Salem	NJ
Mountainside Hospital	Montclair	NJ
Muhlenberg Medical Center	Plainfield	NJ
St. Michael's Medical Center	Newark	NJ
Presbyterian Hospital	Albuquerque	NM
Presbyterian North Side Hospital	Albuquerque	NM
HealthSouth Hospital at Tenaya	Las Vegas	NV
Deaconess Center	Buffalo	NY
St. Mary's Hospital	Amsterdam	NY
Brown County Regional Hospital	Georgetown	OH
Conneaut Medical Center	Conneaut	OH
Geneva Medical Center	Geneva	OH
Hillside Rehabilitation Hospital	Warren	OH
Mahoning Valley Hospital	Warren	OH
Mahoning Valley Hospital LTAC	Boardman	OH
Select Specialty Hospital	Akron	OH
St. Thomas Hospital	Akron	OH
Summa Health	Akron	OH
Logan Medical Center	Guthrie	OK
Willamette Valley Medical Center	McMinnville	OR
Chestnut Hill Healthcare	Philadelphia	PA
HealthSouth Hospital of Pittsburgh	Monroeville	PA
HealthSouth Regional Specialty Hospital	Mechanicsburg	PA
Lock Haven Hospital	Lock Haven	PA
Memorial Hospital	Towanda	PA
Mercy Hospital	Scranton	PA
Mercy Special Care Hospital – Nanticoke	Nanticoke	PA
Mercy Tyler Hospital	Tunkhannock	PA
Moses Taylor Hospital	Scranton	PA
Southwest Regional Medical Center	Waynesburg	PA
St. Francis Hospital Cranberry	Cranberry	PA
St. Francis Hospital of New Castle	New Castle	PA
St. Francis Medical Center	Pittsburgh	PA
Lookout Memorial Hospital	Spearfish	SD
Sturgis Community Health Care Center	Sturgis	SD
Baptist Hospital of Cocke County	Newport	TN
Fentress County General Hospital	Jamestown	TN
Gateway Medical Center	Clarksville	TN
Haywood Park Community Hospital	Brownsville	TN

HOSPITALS:	CITY	ST
McKenzie Regional Hospital	McKenzie	TN
Mercy Medical Center North	Powell	TN
Mercy Medical Center St. Mary's	Knoxville	TN
Mercy Medical Center West	Knoxville	TN
Methodist Healthcare McNairy	Selmer	TN
Methodist Healthcare Volunteer Hospital	Martin	TN
Methodist Healthcare-Brownsville	Brownsville	TN
Methodist Healthcare-Dyersburg	Dyersburg	TN
Methodist Healthcare-Jackson	Jackson	TN
Methodist Healthcare-McKenzie	McKenzie	TN
Methodist Healthcare-Lexington	Lexington	TN
Middle Tennessee Medical Center	Murphysboro	TN
North Coast Medical Center	Springfield	TN
St. Mary's Jefferson Memorial Hospital	Jefferson City	TN
St. Mary's Medical Center of Campbell County	LaFollette	TN
St. Mary's Medical Center of Scott County	Oneida	TN
White County Community Hospital	Sparta	TN
Baptist Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Children's Hospital	San Antonio	TX
CHRISTUS Santa Rosa Hospital-City Centre	San Antonio	TX
CHRISTUS Santa Rosa Hospital-Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Hospital-New Braunfels	New Braunfels	TX
CHRISTUS Santa Rosa Hospital-Westover Hills	San Antonio	TX
CHRISTUS Spohn Hospital Alice	Alice	TX
CHRISTUS Spohn Hospital Corpus Christi Memorial	Corpus Christi	TX
CHRISTUS Spohn Hospital Corpus Christi South	Corpus Christi	TX
CHRISTUS Spohn Hospital Kleberg	Kingsville	TX
Dell Children's Medical Center	Austin	TX
East El Paso Physicians' Medical Center	El Paso	TX
Gulf Coast Medical Center	Wharton	TX
HealthSouth Hospital of Houston	Houston	TX
Highland Medical Center	Lubbock	TX
LifeCare Hospitals of Ft. Worth	Ft. Worth	TX
LifeCare Hospitals of Plano	Plano	TX
LifeCare Hospitals of San Antonio	San Antonio	TX
Longview Regional Medical Center	Longview	TX
Medical Center of Mesquite	Mesquite	TX
North Central Baptist Hospital	San Antonio	TX
Northeast Baptist Hospital	San Antonio	TX

HOSPITALS:	CITY	ST
Renaissance Hospital of Groves	Groves	TX
Renaissance Hospital of Dallas	Dallas	TX
Renaissance Hospital of Houston	Houston	TX
San Angelo Community Medical Center	San Angelo	TX
Seton Medical Center Williamson	Round Rock	TX
Southeast Baptist Hospital	San Antonio	TX
South Texas Spine & Surgical Hospital	San Antonio	TX
St. Luke's Baptist Hospital	San Antonio	TX
Texas Specialty Hospital	Houston	TX
Trinity Community Medical Center of Brenham	Brenham	TX
Trinity Medical Center	Carrollton	TX
Jordan Valley	West Jordan	UT
Rocky Mountain Medical Center	Salt Lake City	UT
Lee Community Hospital	Pennington Gap	VA
St. Mary's Hospital	Norton	VA
Empire Health Services	Spokane	WA
Lourdes Medical Center	Pasco	WA
St. Joseph Regional Medical Center	Lewiston	WA
Valley Medical Center	Renton	WA
LifeCare Hospitals of Wisconsin	Pewaukee	WI
Aurora Medical Center Grafton	Grafton	WI
Aurora Medical Center Oshkosh	Oshkosh	WI
Aurora Medical Center Summit	Summit	WI
Sacred Heart Hospital	Eau Claire	WI
St. Joseph's Hospital	Chippewa Falls	WI
St. Mary's Hospital Medical Center	Green Bay	WI
St. Nicolas Hospital	Sheboygan	WI
St. Vincent Hospital	Green Bay	WI
Bluefield Regional Medical Center	Bluefield	WV
Charleston Area Medical Center	Charleston	WV
Thomas Memorial Hospital	South Charleston	WV

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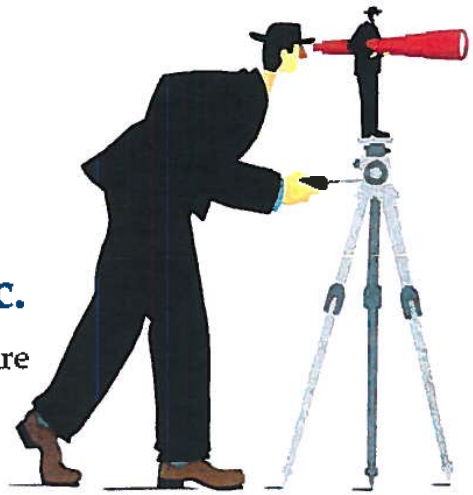
Fairness Opinion
Proposal and Qualifications



Greater Waterbury Health Network, Inc.

LHP Hospital Group, Inc./Saint Mary's Hospital Joint Venture

Michael Lane
Managing Director
312.583.2132

Gregory Hagood
Managing Director
404.504.2017

September 28, 2011

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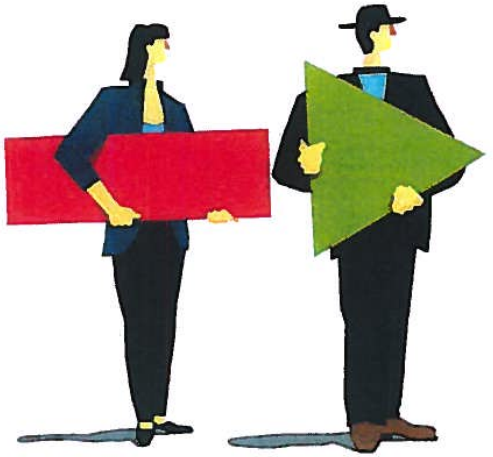
Section 1

Professional Fees/Timeline



Navigant Capital Advisors

Proposed Professional Fees

- Proposed Fixed Professional Fees: [redacted]
  - NCA professional fees are not contingent on the outcome of the opinion
  - Out of pocket expenses will be invoiced separately
- Fairness opinion will be delivered within 45 days of signing an NCA engagement letter containing standard indemnification provisions, and;
  - Will opine on the "fairness", from a financial point of view, of the consideration received in the Transaction which includes the management agreement with an LHP affiliate
  - Will require cooperation from and close working relationship with management
  - Be filed as part of the conversion process application by management
- NCA will NOT opine on, the underlying decision by the Board, relative merits of the transaction, tax or legal aspects of the transaction, solvency or fair value of the Company or any participant to the transaction, the fairness of any portion or aspect of the transaction not expressly addressed in the opinion, or the validity of the information provided in reaching our conclusions.
- Upon signing the engagement letter, NCA will promptly submit a due diligence request list to management requesting certain financial, operational and transactional data and information.
- NCA will comply with the Terms of Engagement as outlined in the request for proposal.

We have conducted our conflict of interest review and have identified NO conflicts to this proposed transaction precluding Navigant Capital Advisors, LLC from rendering a Fairness Opinion

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Navigant Capital Advisors

Proposed Timeline

- Week 1: Sign Engagement Letter and submit due diligence request list to Management.
- Week 2: Meet with Board and Management on site for interviews/due diligence/analysis
- Week 3: Conduct due diligence/analysis
- Week 4: Conduct due diligence/analysis/meetings with Management
- Week 5: Complete analysis and presentation and review with Management/Board
  - ➢ Historical Timeline and Overview of the Hospital
    - ✓ Identification of key events
    - ✓ Statistical and operational summary
    - ✓ Payor analysis and summary
    - ✓ Market, demographics and competition
    - ✓ Financial analysis/earnings normalization
  - ➢ Update market and valuation metrics and key considerations
  - ➢ Analysis of Transaction terms and conditions
  - ➢ Summarize results/findings in presentation format
- Week 6: Finalize analysis and Render Fairness Opinion

Section 2

Navigant Capital Advisors Overview

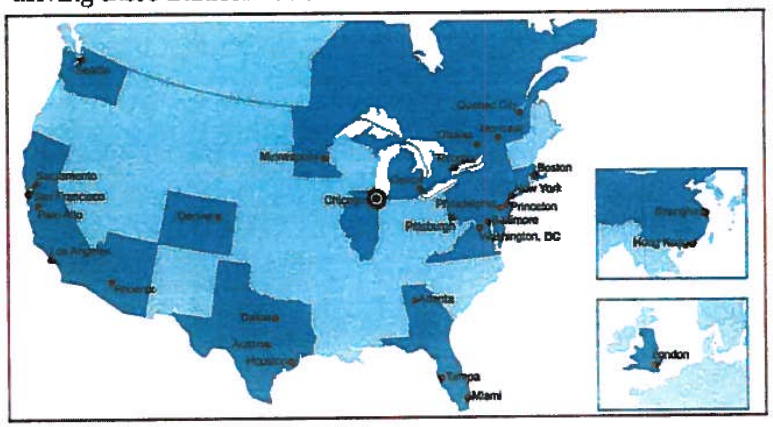
Navigant Consulting
Our Parent

Navigant Consulting, Inc. ("NCI") is the parent company of Navigant Capital Advisors, LLC ("NCA")

Business Description

Navigant Consulting, Inc. is a specialized, independent advisory firm that supports companies, lenders, institutional investors, legal counsel, and government agencies. The company focuses on entities and industries facing the challenges of uncertainty, risk, distress and significant change, and on the issues driving these transformations.

Ticker	NCI (NYSE)
2010 Revenue	$703.7 million
Professionals	1,900+
Headquarters	Chicago, IL



Senior Management

- William M. Goodyear, CEO and Chairman, NCI
- Edward R. Casas, Senior Managing Director, Head of NCA
- Michael lane, Managing Director Healthcare Restructuring
- Greg Hagood, Managing Director, Head of Investment Banking
- David P. Zito, Managing Director, Head of Healthcare Consulting

NCI's 1,900+ professionals maintain presence in 45 cities internationally throughout North America, as well as Europe and Asia.

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Navigant Consulting, Inc.

Business Segment Overview

Our ability to integrate proven advisory skills with industry expertise creates a compelling proposition for our clientele

Navigant Consulting, Inc.

Business Advisory Services	Financial Advisory Services (Navigant Capital Advisors)	Disputes & Investigations
Business advisory services with dominant positions in highly regulated industries including healthcare, energy, construction and insurance and claims.	Full spectrum of financial advisory services with wide industry specialization including: healthcare, manufacturing and distribution, financial services, specialty retail and consumer, business services, energy and construction / real estate.	Litigation, fraud, forensic accounting, investigations, discovery services and government contract dispute services.
■ Strategic Advisory ■ Performance improvement ■ Interim Management ■ Markets & Transactions ■ Technology Strategy & Management ■ Financial and Compliance Advisory ■ Operations Advisory ■ Project Advisory ■ Claims Management ■ Clinical Improvement ■ Insurance Coverage Analysis & Support ■ Data & Information Management ■ Operations & Systems Consulting / Outsourcing ■ Business Process Assessment & Management	■ Restructuring ➢ Capital ➢ Operating ■ Investment Banking ➢ Sell Side ➢ Buy Side ➢ Private Placement ■ Valuation ➢ Enterprise Valuations ➢ Intangible Assets ■ Economic Advisory ➢ Anti-trust & Competition ➢ Securities Litigation ➢ Complex Securities Asset Pricing ➢ Detailed Market Analysis	■ Impact Analysis ■ Fact Finding ■ SEC Investigations ■ Discovery Assistance ■ Deposition Support ■ Expert Testimony ■ Quantifying Losses due to Fraud ■ White Collar Criminal Defense ■ Electronic Records Management ■ Consultation on Financial Reporting Matters ■ Special Investigations ■ Emerging Contractor Services

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Navigant Consulting, Inc.

A Full Spectrum of Healthcare Services

Navigant offers a full spectrum of operational and financial advisory services for healthcare organizations

Strategic Advisory	Operations Advisory and Management	Financial Advisory
Navigant provides healthcare executives with objective, practical, results-oriented assistance to address the business challenges facing their organizations.	Navigant has extensive experience and a successful track record in helping healthcare organizations improve their financial, operational and quality performance.	Navigant offers a full range of financial services and assist healthcare organizations in confronting challenges, identifying solutions and achieving results within a short timeframe.
▪ Enterprise-wide strategic plans ▪ Business plan development and validation ▪ Program and service line analysis ▪ Portfolio analysis and planning ▪ Market research, analysis and forecasting ▪ Product planning, launch and life cycle strategies ▪ Pricing and reimbursement strategy, design and implementation ▪ Public policy evaluation and design ▪ Physician collaboration and integration planning	▪ Comprehensive operational assessment, performance improvement plan development and execution support ▪ Revenue cycle performance improvement ▪ Supply chain management and procurement assistance ▪ Clinical throughput and capacity management ▪ Quality improvement ▪ Physician services and medical staff development ▪ Contract monitoring and oversight ▪ Federal reporting requirements	▪ Due diligence reviews and enterprise valuation ▪ Financial forecasting of policy and program changes ▪ Rehabilitation and performance improvement plan forecasting ▪ Strategic alternatives assessment ▪ Merger, acquisition and divestiture services ▪ Dept capacity analysis and capital restructuring ▪ Recapitalization and rescue financing ▪ Bankruptcy advisory support ▪ Intra-capital structure constituent negotiations

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Navigant Consulting, Inc.

A Full Spectrum of Healthcare Services (cont.)

Navigant offers a full spectrum of operational and financial advisory services for healthcare organizations

Interim Management	Risk Mitigation and Compliance	Dispute Resolution and Avoidance
Navigant provides interim leaders to manage healthcare organizations during challenging times, such as transitioning to a new executive, responding to an unexpected departure or absence, managing a turnaround or implementing a merger. Our professionals have the skills, experience and a track record of rapidly achieving desired results.	Navigant offers solutions that enable our clients to function more efficiently and effectively in the ever changing regulatory framework of the healthcare industry.	Navigant offers support services that draw upon both our litigation experience and our wealth of healthcare industry knowledge.
▪ Chief Restructuring Officer ▪ Chief Executive Officer ▪ Chief Implementation Officer ▪ Chief Financial Officer ▪ Chief Operating Officer ▪ Chief Information Officer ▪ Chief Nursing Officer ▪ Vice President Medical Affairs ▪ Other key operational positions	▪ Compliance plan design and implementation ▪ Compliance effectiveness reviews ▪ Regulatory and operating compliance assessment, risk analysis and quantification ▪ Statistical sampling plans for evaluating over/under payments ▪ Billing and reimbursement audits ▪ Voluntary disclosures ▪ Corporate integrity agreement design and implementation ▪ Independent Review Organization ("IRO") services	▪ Document and electronic data discovery efforts, including preparing discovery requests and accumulating, managing and researching document populations ▪ Electronic data warehousing and analysis ▪ Class certification issues ▪ Liability and damage issues ▪ Deposition and trial preparation ▪ Econometric models to identify risk areas and estimate potential damages ▪ Expert testimony in depositions and at trial

NAVIGANT
CAPITAL ADVISORS

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Navigant Capital Advisors

A Full Spectrum of Financial Services to the Healthcare Industry

Investment Banking	Valuations & Fairness Opinions	Restructuring

Multidisciplinary Team

NCA team members bring significant transactional, operational, financial and legal experience to all engagements and have broad experience in a wide range of industries.

Market Insight

Through a network of industry, private equity and financing contacts, as well as proprietary data sources, NCA keeps abreast of rapidly changing market environments and industry trends affecting its clients and presenting opportunities and challenges to its stakeholders.

Depth/Breadth of Services

- **Merger and Acquisition Advisory**
  - Exclusive Sale
  - Buy Side Advisory
  - Distressed Asset sale
  - Recapitalizations
  - Corporate Divestiture
- **Private Placements**
  - Institutional Debt
  - Institutional Equity
- **Capital Markets Advisory Services**
- **Corporate Development Services**

- **Fairness Opinions**
- **Financial Reporting**
  - Business valuations
  - SFAS 123 (r), 141, 142, 144
  - Derivatives
  - Intangible Asset Valuations
- **Tax**
  - Section 409A
  - Change in Control Section 382
  - Gift and Estate Tax valuations
  - IRC Section 338

- **Financial & Operational restructuring**
- **Creditor Rights Advisory**
- **Interim and Crisis Management**
- **Bankruptcy Planning and Reorganization**
- **Distressed Real Estate Advisory**

NAVIGANT
CAPITAL·ADVISORS

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Navigant Capital Advisors

Consistently Ranked as Top Distressed Financial Advisors in The Deal League Tables

Second Quarter 2011

Rank	Adviser	Investment Bank	Active Cases
1	Casas, Edward	Navigant Capital Advisors LLC	12
1	Barrow, J. Gregory	General Capital Partners LLC	12
1	Turia, Neil	Navigant Capital Advisors, LLC	10
3	Manning, Jeffrey	BDO Capital Advisors LLC	9
4	Hilty, Jack	Navigant Capital Advisors LLC	8
4	Williams, Brent	Duff & Phelps Corp.	8
5	Wu, Christopher	Carl Marks Advisory Group	7
6	Owsley, Henry	Gordian Group LLC	6
7	Caldwell, Patricia	Gordian Group LLC	5
7	Hardie, William	Houlihan Lokey Inc.	5
7	Kaufman, Peter	Gordian Group LLC	5
7	Kurtz, David	Lazard	5
7	Madden, John	Duff & Phelps Corp.	5
7	Murphy, Brendan	Duff & Phelps Corp.	5
8	Decker, James	Morgan Joseph TriArtisan Group	4
8	Feltman, James S.	Mesirow Financial Holdings Inc.	4
8	Geer, Bradley	Houlihan Lokey Inc.	4
8	Henkin, Michael	Jefferies & Co.	4
8	Lattig, Larry H.	Mesirow Financial Holdings Inc.	4

(continued)

2010

Rank	Adviser	Investment Bank	Active Cases
1	Victor, J. Scott	SSG Capital Advisors LLC	13
2	Casas, Edward	Navigant Capital Advisors LLC	12
2	Barrow, J. Gregory	General Capital Partners LLC	12
2	Madden, John	Duff & Phelps Corp.	12
2	Williams, Brent	Duff & Phelps Corp.	12
3	Turia, Neil	Navigant Capital Advisors LLC	10
4	O'Connor, Tim	Broadpoint Gleacher Securities	9
5	Augustine, Neil	Rothschild	8
5	Owsley, Henry	Gordian Group LLC	8
6	Kaufman, Peter	Gordian Group LLC	7
6	Lattig, Larry H.	Mesirow Financial Holdings Inc.	7
6	Murphy, Brendan	Duff & Phelps Corp.	7
6	Ridings, Barry	Lazard	7
7	Belinsky, Russel	Duff & Phelps Corp.	6
7	Derrough, William	Moelis & Co. LLC	6
7	Henkin, Michael	Jefferies & Co.	6
7	Herman, David	Gordian Group LLC	6
7	Hufford, Paul	Blackstone Group LP	6
7	Merola, Frank	Jefferies & Co.	6

(continued)

2009

Rank	Adviser	Investment Bank	Active Cases
1	Madden, John	Chanin Capital / Duff & Phelps	15
2	Murphy, Brendan	Chanin Capital / Duff & Phelps	12
2	Williams, Brent	Chanin Capital / Duff & Phelps	12
3	Lattig, Larry H.	Mesirow Financial Holdings Inc.	11
4	Casas, Edward	Navigant Capital Advisors LLC	9
4	Turia, Neil	Navigant Capital Advisors LLC	9
4	Belinsky, Russel	Chanin Capital / Duff & Phelps	9
4	Kaufman, Peter	Gordian Group LLC	9
5	Barrow, J. Gregory	General Capital Partners LLC	8
5	Carlson, Thomas	Jefferies & Co.	8
5	Herman, David	Gordian Group LLC	8
5	Manning, Jeffrey R.	Trenwith Group LLC	8
6	Derrough, William	Moelis & Co. LLC	7
6	Feltman, James S.	Mesirow Financial Holdings Inc.	7
6	Hardie, William	Houlihan Lokey	7
6	Owsley, Henry	Gordian Group LLC	7
6	Pickering, Ben	Mesirow Financial Holdings Inc.	7
6	Strom, Steve	Jefferies & Co.	7
6	Victor, J. Scott	SSG Capital Advisors LLC	7

(continued)

2008

Rank	Adviser	Investment Bank	Active Cases
1	Casas, Edward	Navigant Capital Advisors LLC	16
2	Turia, Neil	Navigant Capital Advisors LLC	12
2	Feltman, James	Mesirow Financial Holdings Inc.	12
3	Lattig, Larry	Mesirow Financial Holdings Inc.	10
4	Barrow, J. Gregory	General Capital Partners LLC	9
4	Hilty, David	Houlihan Lokey	9
4	Murphy, Brendan	Chanin Capital Partners LLC	9
5	Madden, John	Chanin Capital Partners LLC	8
6	Kaufman, Peter	Gordian Group LLC	7
6	Owsley, Henry	Gordian Group LLC	7
7	Belinsky, Russel	Chanin Capital Partners LLC	6
7	Victor, J. Scott	National City Corp.	6
8	Augustine, Neil	Rothschild	5
8	Burian, Saul	Houlihan, Lokey, Howard &	5
8	Derrough, William	Moelis & Co. LLC	5
8	DiMauro, Chris	Houlihan, Lokey, Howard &	5
8	Manning, Jeffrey R.	Trenwith Group	5
8	Miller, Henry S.	Miller Buckfire & Co. LLC	5
8	Siegert, Eric	Houlihan, Lokey, Howard &	5

(continued)

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Source: The Deal.com Bankruptcy League Tables. Rankings include all debtor, creditor and other assignments within active bankruptcy cases.

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Navigant Capital Advisors

Acute Care Hospital Experience

- NCA has orchestrated multiple competitive bidding auction processes for the sale of acute care hospitals and related assets associated with healthcare delivery systems
- Extensive experience with sales of not-for-profit hospitals
  - In-depth knowledge of various affiliation arrangements, capital structures , and regulatory issues, including conversions
- Relevant Experience:
  - Identifying and advising Hospital Boards with regard to strategic options
  - Positioning hospital assets for sale
  - Working with physicians, employees and other stakeholders to identify and manage needs and concerns
  - Identification of conflicts and regulatory issues
  - Oversight of competitive auction processes
  - Identification of industry and market dynamics

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Navigant Capital Advisors

NCA Recent Not-for-Profit Hospital Transactions

Healthcare System	Description	Transaction	NCA Role
Caritas Christi Healthcare System	Owner of six 501(c)3 Catholic hospitals in Eastern MA	Sale of non-profit hospitals to Cerberus Capital Management and conversion to for-profit status.	Financial advisor engaged to review transaction terms and conditions and issue a Fairness Opinion. Navigant was initially retained to provide a strategic review and assessment related to identifying capital alternatives for this non-profit organization
Sumner Regional Healthcare System	Three 501(c)3 hospital healthcare organization serving eleven counties in middle Tennessee	Sale of non-profit hospitals to Lifepoint Hospital Corporation pursuant to Section 363 under Chapter 11 of the U.S. Bankruptcy Code and conversion to for-profit status.	Financial advisor in bankruptcy and in connection with exploring strategic alternatives; also served as interim management. NCA led a competitive sale process whereby numerous offers were obtained and negotiated with a wide array of national and regionally-focused hospital companies.
Twin City Hospital System	A twenty-five bed, not-for-profit 501(c)3, critical access hospital located in Dennison, Ohio	Sale to hospital Franciscan Services Corp. pursuant to section 363 under Chapter 11 of the U.S. Bankruptcy Code.	Financial advisor in connection with exploring strategic alternative and managing auction process.
Morton Hospital and Medical Center	154-bed not-for-profit 501(c)3 acute care hospital offering a full spectrum of medical and surgical services located in Taunton, MA	Sale of non-profit hospital to Steward Health Systems and conversion to for-profit status.	Financial advisor in connection with exploring strategic alternatives including identifying a capital or affiliation partner. Navigant was initially retained to provide a strategic review and assessment related to identifying capital alternatives. Structured transaction and worked through issues with the Attorney General.
Tomball Regional Medical Center	Municipal hospital in Tomball, Texas with 358 licensed beds and a medical staff of over 360 physicians	Sale of non-profit hospital to Community Health Systems (NYSE: CYH) and conversion to for-profit status.	Financial advisor for managing a competitive process to identify strategic alternatives including the sale of the hospital and other non-core assets and worked through conversion process.
Quincy Medical Center ("QMC")	Not-for-profit 501(c)3 acute care community hospital located in Quincy, MA with 196 licensed beds and over 340 physicians	Sale of non-profit hospital to Steward Medical Holdings (pending) pursuant to Section 363 under Chapter 11 of the U.S. Bankruptcy Code, and conversion to for-profit status.	Financial advisor for i) managing a competitive process to identify strategic alternatives including the sale of the hospital and other non-core assets, ii) negotiating with QMC's bondholders and other creditors regarding financial restructuring matters.

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Navigant Capital Advisors

Leading Investment Bankers for Healthcare – recent transactions

$630,000,000
Caritas
has been acquired by
Cerberus
Financial Advisor

$48,000,000
Morton Hospital & Medical Center
Is being acquired by
Steward Medical Holdings
Pending
Sell Side Advisor

$156,000,000
Sumner Regional Health Systems, Inc.
Financial Advisor,
Chief Executive Officer
Chief Restructuring Officer

$38,000,000
Quincy Medical Center
is being acquired by
Steward Medical Holdings
Pending
Sell Side Advisor

MedCath
MedCath Corporation
(Nasdaq: MDTH)
Financial Advisor

$76,250,000
TexSan Heart Hospital
has been acquired by
Methodist Healthcare
System of San Antonio
Sell Side Advisor

Tomball Regional Medical Center
Is being acquired by
Community Health
Systems
Pending
Sell Side Advisor

$32,000,000
Arizona Heart Hospital
has been acquired by
Vanguard Health Systems
Sell Side Advisor

Riverview Regional Medical Center
has been acquired by
LifePoint Hospitals
Sell Side Advisor

$7,000,000
An equity interest in
Southwest Arizona Heart and Vascular Center, LLC
has been acquired by
its physician partners
Sell Side Advisor

Brotman Medical Center
Financial Advisor,
Chief Executive Officer and
Chief Restructuring Officer

$20,000,000
An equity interest in
Avera Heart Hospital of South Dakota
has been acquired by
Avera McKennan
Sell Side Advisor

Trousdale Medical Center
has been acquired by
LifePoint Hospitals
Sell Side Advisor

$83,800,000
Heart Hospital of Austin
has been acquired by
St. David's Healthcare
Partnership, L.P.
Sell Side Advisor

$939,000,000
BCM
Baylor College of Medicine
Financial Advisor

Navigant Capital Advisors

Key Qualifications

- NCA has developed its fairness opinion practice based on "best practices" and decades of experience:
  - NCA professionals have extensive experience advising Boards of Directors and independent/special committees
  - Truly independent financial advisor
  - Procedures and documentation incorporate existing and proposed rules and regulations
  - Rigorous review of prospective projects
  - Deliberate assignment of each execution team based on skill set
  - Independent stature of Fairness Opinion Operating Committee—approvals and reviews
  - Members of the execution team and Fairness Opinion Operating Committee have both technical and transaction experience

Navigant Capital Advisors

Fairness Opinion Capabilities

Fairness Opinion Practice

As part of Navigant's Valuation Services practice, we have a fully integrated Fairness Opinion practice. Our practice conforms to applicable FINRA standards for independence and internal reviews to assure a rigorous, well-researched conclusion for our clients.

Level of Sophistication

We have significant experience executing transactions for publicly traded companies including cross-border acquisitions, divestitures, reverse mergers and complex second lien financings.

Senior Level Attention

Navigant Capital Advisor's Senior Professionals are well seasoned with significant transactional experience who will manage your transaction from initiation to close.

Full Service Advisory Firm

We provide a comprehensive and integrated suite of advisory services including sell-side representation, capital sourcing of debt and equity, corporate assessments, strategic advisory, financial restructuring, fairness opinions and due diligence services.

Financial Strength

With an enterprise value exceeding $700 million and a market capitalization of approximately $500 million, NCI has the financial strength to stand with its clients even years from now.

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Section 3

Benefits of Fairness Opinion

Benefits of a Fairness Opinion

When Does a Fiduciary Need a Fairness Opinion?

- Fairness opinions are not required by any statute or regulation, but they have become a regular feature of corporate transactions since 1985 when the Delaware Supreme Court issued its Opinion in Smith v. Van Gorkum.
- The Court found that a corporate board breached its fiduciary duty of care by approving a merger without *adequate information on the transaction,* including information on *the value of company* and *the fairness of the offering price.*
- It was not the price itself that was questioned, only that *there was no independent evidence* that that the price was fair.
- Fairness Opinions serve two main purposes:
  - Provide boards of directors or trustee with information which to evaluate a transaction; and;
  - Serve as evidence in litigation that the board of directors used reasonable business judgment in approving the transaction

Benefits of a Fairness Opinion

When Does a Fiduciary Need a Fairness Opinion?

- Corporate boards of directors or trustees frequently obtain an independent opinion to assess the fairness of certain contemplated transactions having a significant impact on an organization's value.
- Fairness opinions are generally rendered for the following transactions:
  - Mergers and acquisitions
  - Employee Stock Ownership Plans (ESOP)
  - Going private transactions with Equity private placements
  - **Not-For–Profit Conversions**
- Issues for which Fairness Opinions are generally recommended include:
  - A fiduciary wants an independent advisor to support its actions
  - Tender offer, sale or merger is conducted without an auction
  - Minority shareholders are being bought out
  - Significant change in capital structure
  - Prospects of dilution
  - Management, board members, or controlling holders benefit from the transaction
  - Multiple constituencies or shareholders

Benefits of a Fairness Opinion

What is included in a Fairness Opinion?

- Fairness opinions historically have been delivered in the form of a letter addressed to:
  - A company's Board of Directors
  - A special committee of independent directors formed to consider a proposed transaction
  - Trustees or other fiduciaries responsible for evaluating a corporate transaction
- The opinion is backed by a supporting presentation detailing the methods used and the analysis leading to the conclusion.
- Fairness Opinions typically include the following
  - Description of the proposed transaction;
  - Summary of the financial advisor's due diligence investigation;
  - Statement of any limitations on use;
  - Statement of conclusion (example, that the proposed transaction or consideration received is fair, from a financial point of view).

Benefits of a Fairness Opinion

What is included in a Fairness Opinion?

- A Fairness opinions is:
  - A financial advisor's opinion that states whether or not the financial terms of a proposed transaction are within a range of fairness;
  - Expressed from a financial point of view to one or more specific parties of the proposed transaction as of a specific date.
- A Fairness opinions Is NOT:
  - An opinion that the proposed transaction is fair from a legal point of view;
  - A recommendation for the proposed transaction;
  - An evaluation of the business rationale to proceed with a transaction.

Benefits of a Fairness Opinion

What is Considered in Rendering a Fairness Opinion?

- In preparing a fairness opinion, financial advisors must:
  - Utilize proven valuation techniques;
  - Implement thorough industry analysis and extensive due diligence
  - Include a rigorous analysis of the available alternatives to the proposed transaction
- Key question is "Are the shareholders or beneficiaries better off with or without the proposed Transaction?"
- In a cash transaction, an advisor should analyze whether the consideration to be paid falls within the fairness range and what alternatives exist.
- In a transaction involving a non-cash exchange, an advisor should consider the relative benefits to the selling organization's stakeholders owning the buyer's stock.
- The following are NOT a consideration:
  - Is a better deal available?
  - Are there Anti-Trust concerns?

Benefits of a Fairness Opinion

What is Considered in Rendering a Fairness Opinion?

- All types of consideration must be valued, including management contract fees, contingent payments and percentage ownership in a joint venture.
- A financial advisor must analyze:
  - The relative consideration received by various parties;
  - *Other financial terms of the transaction*
  - Any financial alternatives that may be available to the shareholders or beneficiaries
- High level of due diligence are required for:
  - History of the transaction
  - Marketing of the deal
  - Projections
- No formal standard of value exists for the preparation of Fairness Opinions.
- It is necessary to consider all the material facts and circumstances of the proposed transaction when determining the standard of value.

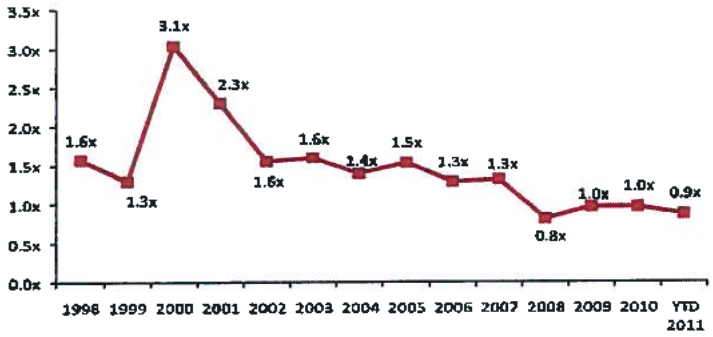
Section 4

Market Overview

Current Hospital Valuation Trends

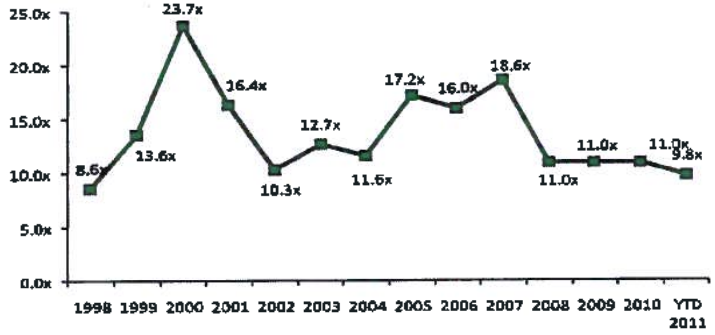
Valuation Trends for Publicly Traded Hospital Companies

Enterprise Value / Revenue

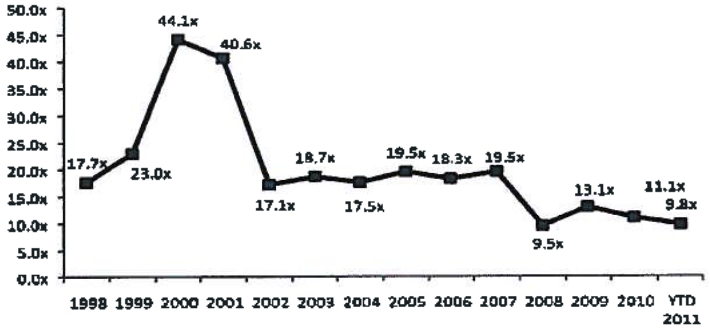


Enterprise Value / EBITDA

Enterprise Value / EBIT



Price to Earnings



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Note: The graphs are representative of the companies within the "NCA Hospital Index" which includes CYH, HMA, LPNT, THC, and UHS. Source: Capital IQ

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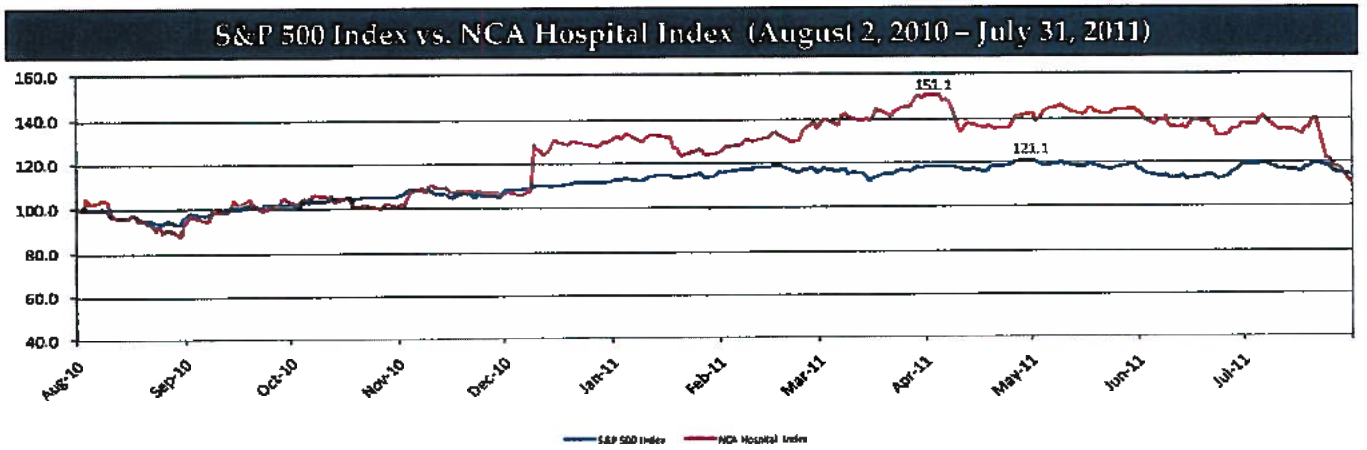
Current Hospital Valuation Trends

Comparable Companies Publicly Traded

- Publicly Traded Hospitals currently trade at a median multiple of 0.9x revenue and 6.6x EBITDA



($ in millions, except per share data)		Stock Price	% of 52 Wk	Enterprise	Latest Twelve Months (LTM)			Cal Year 2011		Enterprise Value/ LTM		Enterprise Value/ CY 2011	
Company Name	Ticker	8/1/11	High	Value	Revenue	EBITDA	EBITDA %	Revenue	EBITDA	Revenue	EBITDA	Revenue	EBITDA
Community Health Systems, Inc.	CYH	$24.36	57%	$11,666	$13,625	$1,710	12.5%	$14,755	$1,929	0.9x	6.8x	0.8x	6.0x
HCA Holdings, Inc.	HCA	$24.94	71%	38,786	31,501	5,566	17.7%	34,318	6,336	1.2x	7.0x	1.1x	6.1x
Health Management Associates Inc.	HMA	$8.96	76%	5,023	5,442	781	14.4%	6,219	884	0.9x	6.4x	0.8x	5.7x
Lifepoint Hospitals Inc.	LPNT	$35.57	82%	3,176	3,452	541	15.7%	3,789	574	0.9x	5.9x	0.8x	5.5x
Tenet Healthcare Corp.	THC	$5.44	71%	6,881	9,443	1,140	12.1%	10,137	1,295	0.7x	6.0x	0.7x	5.3x
Vanguard Health Systems Inc.	VHS	$16.33	88%	3,054	4,896	404	8.2%	6,530	569	0.6x	7.6x	0.5x	5.4x
High:										**1.2x**	**7.6x**	**1.1x**	**6.1x**
Low:										**0.6x**	**5.9x**	**0.5x**	**5.3x**
Mean:										**0.8x**	**6.6x**	**0.8x**	**5.7x**
Median:										**0.9x**	**6.6x**	**0.9x**	**5.6x**

Source: Capital IQ

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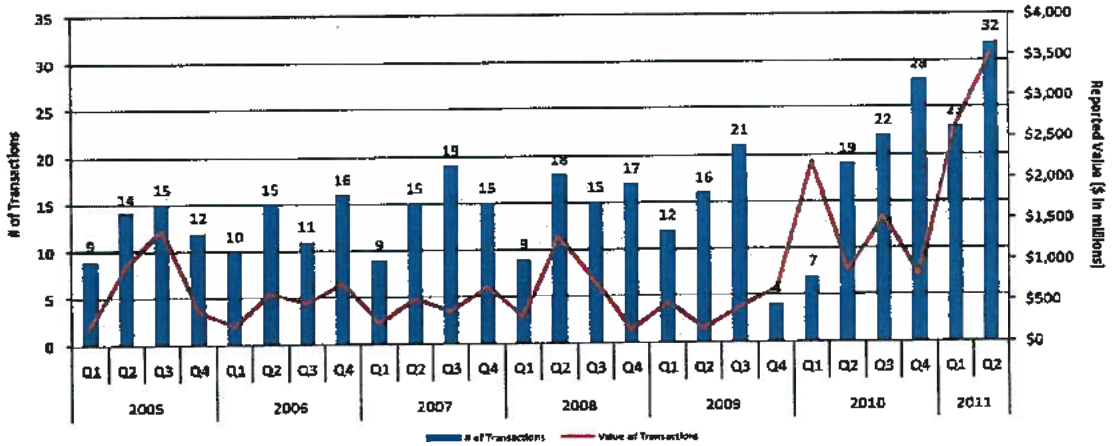
Current Hospital Valuation Trends

Recent Hospital M&A Activity

- Hospital M&A Activity has increased over past year due to:
  - Recessionary impact on community owned hospitals
  - Increasing capital investment required to remain competitive
  - Favorable valuations

Hospital M&A Transactions by Quarter



Notable Transactions:

[1] In Q3 2006, the privatization of HCA, Inc. by a private equity consortium affected 176 acute-care hospitals. The acquisition was the largest healthcare transaction ever announced at approximately $33.0 billion. This acquisition is not included above.

[2] In Q1 2007, Triad Hospitals, Inc. was acquired by Community Health Systems, Inc. (NYSE: CYH) for approximately $6.8 billion. This acquisition is not included above.

[3] Q1 2010 value includes the acquisition of Detroit Medical Center by Vanguard Health Systems, Inc. for approximately $1.267 billion.

[4] Q4 2010 value does not include the acquisition of Tenet Healthcare by Community Health Systems for approximately $7.3 billion.

Source: Irving Levin Associates, Inc.

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Current Hospital Valuation Trends

Comparable Precedent Transactions

- Based upon 41 publicly disclosed hospital acquisitions from 2010 and 2011, acquisition multiples imply median values of 0.68x revenue and 6.7x EBIDA, respectively.

($ in millions, except price per bed)

			Whole Company Transactions Method Multiples							
			Target:				Transaction	Transaction Value [2]		
Date	Buyer	Target	ST	Status	Revenue	EBIDA [1]	Beds	Value	Revenue	EBIDA	Bed
08/29/11	Kingman Regional Medical Center	Hualapai Mountain Medical Center	AZ	For Profit	NA	NA	70.0	31.0	NA	NA	442,857
07/25/11	Duke LifePoint Healthcare, LLC	Maria Parham Medical Center	NC	For Profit	97.8	11.9	102	76.6	0.8x	6.4x	750,980
07/01/11	Health Management Associates, Inc.	Mercy Health Partners, Inc.	TN	Nonprofit	809.0	NA	833.0	525.0	0.6x	NA	630,252
06/15/11	HCA, Inc.	Remaining interest in HealthONE	CO	For Profit	NA	NA	1,300	1,450.0	NA	NA	966,667
06/07/11	Steward Health Care System	Landmark Medical Center	RI	Non-profit	NA	NA	203.0	76.5	NA	NA	377,340
05/25/11	University of Maryland Medical System	Civista Health System	MY	Non-profit	100.8	NA	130	16.5	0.2x	NA	126,923
05/18/11	LifeCare Holdings, Inc.	Six long-term acute care hospitals	AL	For Profit	121.7	17.5	414.0	120.0	1.0x	6.9x	289,855
05/13/11	South Georgia Medical Center	Smith Northview Hospital	GA	For Profit	41.4	6.1	45	40.0	1.0x	6.6x	888,889
05/10/11	Franciscan Services Corp.	Twin City Hospital	OH	Non-profit	16.8	NA	25.0	4.9	0.3x	NA	196,000
05/09/11	AR-MED, LLC	Arkansas Heart Hospital	AK	For Profit	117.5	17.4	112	60.0	0.5x	3.4x	535,714
04/25/11	HUMC Holdco	Hoboken University Medical Center	NJ	Non-profit	115.9	NA	230.0	91.7	0.8x	NA	398,696
04/20/11	Health Management Associates, Inc.	Tri-Lakes Medical Center	MS	For Profit	30.3	NA	112	39.0	1.3x	NA	348,214
04/19/11	Adventist Health	Sierra Kings District Hospital	CA	Non-profit	22.1	NA	44.0	24.8	1.1x	NA	563,636
03/31/11	Sabra Health Care REIT	Texas Regional Medical Center	TX	For Profit	NA	NA	70	62.7	NA	NA	895,714
03/25/11	Yale-New Haven Hospital	Hospital of Saint Raphael	CT	Non-profit	450.3	15.4	511.0	135.0	0.3x	8.8x	264,188
03/18/11	Iasis Healthcare	St. Joseph's Medical Center	TX	Non-profit	245.0	NA	782	156.8	0.6x	NA	197,980
03/09/11	Franciscan Services Corp.	Twin City Hospital	OH	For Profit	15.8	NA	25.0	4.9	0.3x	NA	194,000
03/04/11	Trinity Health Corporation	Loyal University Health System	IL	Non-profit	1,100.0	NA	820	475.0	0.4x	NA	579,268
02/23/11	Steward Health Care System	Jackson Health System	FL	Non-profit	NA	NA	2,482.0	1,100.0	NA	NA	443,191
02/10/11	Community Health Systems, Inc.	Mercy Health Partners	PA	Non-profit	183.9	NA	313	150.0	0.8x	NA	479,233
02/01/11	UPMC Health System	Horrot Medical Center	PA	Non-profit	315.2	33.0	351.0	300.0	1.0x	9.1x	854,701
01/17/11	Sisters of Mercy Health System	Johnston Memorial Hospital	OK	Non-profit	3.8	NA	15	1.6	0.4x	NA	106,667
12/21/10	Hospital Authority of Albany-Dougherty	Palmyra Park Hospital	GA	For profit	155.5	NA	248.0	195.0	1.2x	NA	786,290
12/21/10	Medical Properties Trust Inc.	Three Long-Term Acute Care Hospital Facilities	Various	For Profit	NA	NA	220	99.5	NA	NA	452,273
12/20/10	Healthcare Trust of America, Inc.	Multi-state Portfolio	Various	For profit	NA	NA	208.0	102.0	NA	NA	489,254
12/10/10	Grubb & Ellis Healthcare REIT II, Inc.	Humble Surgical Hospital, LLC	TX	For profit	NA	NA	NA	13.1	NA	NA	NA
11/17/10	Prime Healthcare Services, Inc.	Alvarado Hospital Medical Center, Inc.	CA	For profit	178.4	8.1	2,437.0	40.0	0.2x	6.6x	16,414
10/26/10	Vibra Healthcare, LLC	Two Indiana LT Acute Care Hospitals	IN	For Profit	NA	NA	NA	21.0	NA	NA	NA
10/26/10	Vibra Healthcare, LLC	Two Ohio LT Acute Care Hospitals	OH	For Profit	NA	NA	NA	21.0	NA	NA	NA
10/12/10	ThedaCare	Shawano Medical Center	WI	Non-profit	NA	NA	25	4.9	NA	NA	172,000
10/11/10	SUNY Downstate Medical Center	Long Island College Hospital	NY	For profit	NA	NA	506.0	110.0	NA	NA	217,391
10/01/10	New Directions Health Systems, LLC	Pike County Memorial Hospital	AR	Non-profit	3.5	0.2	32	2.0	0.6x	8.1x	62,500
09/10/10	Iasis Healthcare	Brim Holdings	TN	For profit	NA	NA	165.0	95.0	NA	NA	575,758
09/02/10	Adventist Health Systems, Inc.	University Community Health, Inc.	FL	Non-profit	502.5	NA	NA	353.0	0.7x	NA	NA
09/01/10	Health Management Associates, Inc.	Wuesthoff Health System	FL	Non-profit	290.0	NA	408.0	151.5	0.5x	NA	373,153
08/30/10	Avera MacKenzie	Avera Heart Hospital	SD	For profit	NA	NA	55	36.0	NA	NA	654,545
08/24/10	Kindred Healthcare Inc.	Five Long Term Acute Care Hospitals	CA	For profit	150.0	27.0	250.0	178.0	1.2x	6.6x	712,000
08/16/10	Management	Prospect Medical Holdings, Inc.	CA	For profit	468.0	54.0	759	363.0	0.8x	6.7x	478,261
08/09/10	Vanguard Health Systems, Inc.	Arizona Heart Hospital	AZ	For profit	NA	NA	58.0	32.4	NA	NA	548,153
08/06/10	Community Health Systems, Inc.	Forum Health	OH	Non-profit	300.4	NA	625	200.0	0.7x	NA	320,000
08/06/10	MHA, LLC	Meadow lands Hospital	NJ	Non-profit	51.6	NA	230.0	16.0	0.3x	NA	69,565

High	1.29x	9.09x	$965,867
Low	0.15x	3.45x	$16,414
Mean	0.66x	6.91x	$444,825
Median	0.68x	6.65x	$442,191

Notes:

[1] For-profit hospital data is before taxes, thus comparable to EBIDA.

[2] High, mean, and median metrics exclude EBIDA multiples > 11x, per Bed multiples > $1 mil.

Source: Irving Levin Associates, Inc, CapitalIQ.

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Section 5

Healthcare Solutions Leadership Team

Healthcare Solutions Leadership Team

Key Member Biographies

EDWARD R. CASAS, MD, MBA, MPH
SENIOR MANAGING DIRECTOR
ecasas@ncacf.com
847.583.1619

Edward R. Casas serves as Senior Managing Director and Head of Navigant Capital Advisors. Dr. Casas specializes in financial restructurings, corporate finance, mergers, acquisitions and divestitures and strategic plan development on behalf of creditors, debtors, equity sponsors, third party purchasers and sellers. As Senior Managing Director and Founding Member of Casas, Benjamin & White, LLC (CBW), which was acquired by Navigant in 2005, Dr. Casas supervised and coordinated the strategy and focus for all aspects of the firm's restructuring engagements, including the assessment of management and operations, the development of business strategy, and the negotiation and execution of capital and operating restructuring initiatives. Over the past 20 years, he has led numerous merger, acquisition and divestiture transaction, as well as reorganizations, in a breadth of industries including healthcare, real estate, construction, hedge funds and other financial institutions, consumer and business services, manufacturing and distribution, entertainment, and technology.

Prior to founding CBW, Dr. Casas served as President and Chief Executive Officer of PrimeCare International, Inc. where he successfully orchestrated the operating and capital restructuring of the national, privately held corporation, ultimately achieving a targeted liquidity objective for the shareholders. Prior to joining PrimeCare, Dr. Casas had national responsibility as Vice President of Mergers & Acquisitions for Caremark International, Inc. a publicly traded (NYSE) Fortune 500 Company. Dr. Casas joined Caremark after he completed his active duty service as a designated Flight Surgeon in the U.S. Navy where he provided support to Marine special operations and served as a Department Head of Aviation Medicine. Before his medical training, Dr. Casas was Executive Vice President of CES Corporation, a specialized investment banking concern.

Dr. Casas has served on the boards of numerous public and private companies, including Reckson Associates, Inc. (NYSE: RA), a $5 billion market cap New York based REIT, and Physician Specialty Corp. (NASDAQ: ENT), an Atlanta based operator of professional services and MedCath Corporation (NASDAQ:MDTH), a healthcare provider focused primarily on the diagnosis and treatment of cardiovascular disease. He has served as Executive Chairman of HQ Global Workplaces, Inc., the largest domestic operator of executive office suites, Mediq, Inc., one of the largest medical equipment related companies, and Tender Loving Care Healthcare Services, Inc., the third largest domestic homecare service operator.

Dr. Casas is a graduate of Northwestern University's Medical School and Kellogg Graduate School of Management where he concurrently earned his Doctor of Medicine, Master of Management, and Master of Public Health degrees. Dr. Casas is a FINRA Series 7, 24 and 63 licensed registered securities principal. He also holds a CIRA certification as a Certified Insolvency & Restructuring Advisor.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

MICHAEL R. LANE
MANAGING DIRECTOR
mlane@ncacf.com
312.583.2132

Michael Lane is a Managing Director in Navigant Capital Advisors' Healthcare practice. He has been involved with the healthcare industry throughout his career for over 30 years, primarily as a financial advisor in troubled situations, a banker and consultant. At Navigant Capital Advisors, he is devoted full time to the healthcare industry with an emphasis on the acute care sector. His areas of specialization include mergers and acquisitions and serving as an advisor to distressed and underperforming healthcare organizations, representing equity sponsors and creditors including banks, bondholders and unsecured committees in evaluating various strategic alternatives in financial restructurings and workouts. Recent engagements include serving as CRO at Catskill Regional Medical Center, Harris, NY, and interim CEO/CRO at Brotman Medical Center, Culver City, CA. In addition, Mr. Lane has been involved with some very high profile M&A transactions including the acquisition of six Catholic Hospitals in Boston, by Cerberus.

Among the recent hospital clients for which Mr. Lane has provided financial advisory services include :

- Caritas Christi Healthcare
- Madison Hospital Center
- Morton Hospital and Medical Center
- Tomball Regional Medical Center
- Brotman Medical Center

He has been involved with mergers and acquisitions over the past 20 years aggregating several billion dollars.

Mr. Lane is a licensed CPA and a member of the AICPA, Illinois CPA Society, the American Bankruptcy Institute and Turnaround Management Association. He is FINRA series 7 and 63 licensed and holds an AIRA certification as a Certified Insolvency and Restructuring Advisors. He holds a Bachelor of Science degree and an MBA from Southeast Missouri State University.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

GREGORY F. HAGOOD
INVESTMENT BANKING PRACTICE LEADER
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404.504.2017

Gregory F. Hagood, CFA is a Managing Director and Practice Group Leader for the Investment Banking Group at NCA where he focuses on providing mergers and acquisitions advisory services and distressed sale and asset liquidation services. During the past decade, he has completed over 100 merger & acquisition and capital placement transactions. Mr. Hagood has extensive transaction experience in the healthcare industry including hospitals, physician practices, healthcare staffing, revenue cycle management and healthcare technology industries.

Currently Mr. Hagood is advising on the disposition of numerous hospital and other healthcare assets in connection with the wind-down of a publicly-traded healthcare system.

Among the recent hospital clients for which Mr. Hagood has provided merger & acquisition advisory services include :

- Caritas Christi Healthcare
- MedCath Corporation
- Morton Hospital and Medical Center
- Tomball Regional Medical Center.
- Quincy Medical Center.

Mr. Hagood received his Master's of Management from the J.L. Kellogg School of Management at Northwestern University and earned a Bachelor of Science degree from the McIntire School of Commerce at the University of Virginia. He is FINRA Series 7, 24 and 63 licensed and is also a Charter Financial Analyst (CFA) and a member of the Atlanta Society of Financial Analysts.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

DAVID P. ZITO
MANAGING DIRECTOR
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312.583.5871

David P. Zito is a Managing Director and serves as practice leader of the Healthcare practice of Navigant Consulting. Mr. Zito has over 20 years of management consulting experience serving integrated healthcare systems, public and private teaching institutions, academic medical centers, faculty practice plans and community hospitals. He has extensive experience in operations improvement, strategic planning, mergers and acquisitions, supply chain management and clinical transformation and specializes in these areas.

Over his career, Mr. Zito has provided a variety of healthcare consulting services such as the manager of a health care system implementation and directed a $150 MM operations improvement initiative at UPMC Health System in Pennsylvania, a $200 MM improvement plan including productivity improvement, supply chain and revenue cycle management, and clinical program redesign for Continuum Health Partners in New York, a $100 MM performance improvement plan at Memorial Hermann Health System in Texas, and also led the post-merger integration planning, and directed the implementation for a $50M performance improvement plan.

Mr. Zito has also led the development of performance improvement plans for other health systems including University Health System in Ohio, Health Alliance in Ohio, Jewish Hospital Health System in Kentucky, St Francis in Peoria, Long Island Jewish, and Phoenix Children's.

Prior to joining Navigant Consulting, Inc., Mr. Zito was a Vice President for Cap Gemini Ernst & Young's Healthcare Consulting practice. During his time at CGEY, he held several leadership positions including, Healthcare Business Unit Leader, Service Line Leader, and Strategy & Operations Service Line Leader.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

DAVID BURIK
MANAGING DIRECTOR
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312.583.4148

David Burik is a Managing Director with Navigant Consulting's healthcare team. He has over 30 years of consulting experience within all segments of the health care industry. His expertise includes the definition and communication of key strategic issues, market and demographics, competitor analysis, as well as the successful execution of the solutions for those issues. Mr. Burik's creativity, listening skills, and ability to respectfully challenge clearly summarize the key issues at hand and facilitate decision making, are recognized throughout the healthcare industry.

Prior to joining Navigant, Mr. Burik spent a majority of his career at Tiber Group and Price Waterhouse. Mr. Burik received his undergraduate degree at Northwestern University and a masters degree in Finance and Hospital Health Services Management from the Kellogg School of Management at Northwestern University. David is an editorial reviewer for the Hospital Financial Management Association and was a recipient of the Follmer Bronze Merit Award.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

KIM BRADY
MANAGING DIRECTOR
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847.583.1718

Kim Brady is a Managing Director with Navigant Capital Advisors and specializes in capital restructuring and operational turnaround on behalf of the firm's clients. He has significant experience negotiating with senior secured creditors, overseeing asset divestitures and dispositions, rehabilitating under-performing companies and executing distressed mergers and acquisitions. While at Navigant Capital Advisors, Mr. Brady has structured and overseen the successful disposition of over 150 business units and has consummated over $5 billion in debt restructuring and $1.5 billion in M&A transactions with an emphasis in the healthcare services, real estate, consumer services, construction, distribution, technology, and basic manufacturing industries.

Mr. Brady works closely with private equity firms, senior secured creditors, unsecured creditors, boards of directors and company management in executing capital and operational restructuring. He has led engagements both in-court and out-of-court. Recent engagements have involved the restructuring of healthcare services, continuing care retirement communities, home nursing, dental management and retail companies. Mr. Brady is skilled in developing capital restructuring solutions and operating initiatives to drive management accountability and to improve profitability and liquidity. He has held a number of interim management roles in the client companies, such as CFO and CRO, in which significant performance improvements were realized, resulting in 100% recovery for capital structure constituents and in the creation of significant equity value for the sponsor.

Before joining Casas, Benjamin & White, LLC, a predecessor to Navigant Capital Advisors, LLC, Mr. Brady served as a General Manager and CFO for Doshi Diagnostic, one of the most profitable out-patient diagnostic centers in the U.S. and VP of Business Development for PrimeCare International. He also has worked in strategic planning and acquisitions for Caremark International, Inc. and as manager of Strategy and Planning, European Operations, for Baxter International, Inc. Mr. Brady received his Bachelor of Science in Finance from the Marriott School of the Brigham Young University and his MBA from Northwestern University's Kellogg Graduate School of Management. Mr. Brady is FINRA Series 7 and Series 63 licensed, and CIRA certified as an Insolvency Restructuring Advisor and certified in Distressed Business Valuation.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

NEIL F. LURIA
MANAGING DIRECTOR

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216.321.5606

Neil Luria is a Managing Director with Navigant Capital Advisors and specializes in capital restructuring and operational support on behalf of the firm's clients. He has significant experience negotiating and structuring acquisitions, divestitures and structured settlements, overseeing asset liquidations, restructuring leases, real estate assets, hedge funds, loan origination and securitization. Mr. Luria joined Casas Benjamin & White, LLC a predecessor of Navigant Capital Advisors in 1999. While at Navigant Capital Advisors (and its predecessor), he has structured and overseen the successful disposition of over 250 business units, with a particular emphasis in healthcare services, real estate, consumer services, and distribution industries. In addition, Mr. Luria has overseen operating and capital restructurings in the capacity of Chief Restructuring Officer.

Mr. Luria has been heavily involved in the restructuring of commercial and residential real estate, including advising investment funds and real estate portfolios with respect to the restructuring of in excess of $15 BB of undeveloped land and $10 BB of commercial office properties. He is currently serving as the Chairman of the Official Committee of Unsecured Creditors of Neumann Homes, Inc., as well as Chairman of the Creditors Committees for subprime originators MILA, Inc. and Oak Street Mortgage. Mr. Luria also sits on the Official Committee of Unsecured Creditors of New Century Financial and People's Choice, two of the largest independent subprime originators. He is currently a member of the Board of Directors of Spectrum Diagnostic Imaging, LLC, one of the largest regional operators of diagnostic imaging centers and was formerly a member of the Board of Directors of Stampede Meats, Inc., one of the largest domestic meat processors. Mr. Luria is currently serving as Liquidating Trustee of Orthodontic Centers of America and Mortgage Lenders Network USA. He is presently one of the most active restructuring professionals in the subprime and Alt-A mortgage industry and is actively involved in the bankruptcies of numerous mortgage originators, on behalf of a large warehouse lender and repurchase claim creditors.

Before joining Navigant Capital Advisors (and its predecessor), Mr. Luria served as President of BMJ Medical Management, Inc., an operator of ambulatory surgery centers, imaging centers and physician practices, where he had previously served as Executive Vice President and General Counsel. While at BMJ, he oversaw the company's liquidation efforts that realized a 100% recovery to its Senior Secured Lenders. Prior to BMJ, he was engaged in the private practice of law at the firm of Jones Day Reavis & Pogue. Mr. Luria's practice involved the representation of venture capital and leverage buyout funds in connection with their portfolio investments, related add-on acquisitions and subsequent divestiture transactions. In addition, he was involved in numerous securities offerings ranging from global initial public offerings to private placements. He has also served as liquidating trustee in several high profile restructuring situations where he held fiduciary roles and was responsible for successfully winding down operations, disposing of liquid and non-liquid assets and over-sighting the litigation claims process.

Mr. Luria received his Juris Doctorate from the Boston University School of Law where he served on the Boston University Law Review and his Bachelor of Science in Economics from the Wharton School of the University of Pennsylvania. He also holds a CIRA certification as a Certified Insolvency & Restructuring Advisor.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

MARK A. BRAZITIS
MANAGING DIRECTOR
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717.203.7508

Mark Brazitis joined Navigant Consulting's Healthcare Practice with over 25 years of industry experience in progressively more responsible roles, including CEO of Lancaster Regional Health and CEO of Lancaster General Hospital. Mr. Brazitis specializes in organizational growth and development, turnarounds, business development and operations improvement. His background includes working with not-for-profit as well as for profit hospitals and health systems. Mr. Brazitis has provided consulting expertise to a variety of hospitals and health systems throughout the country to include OhioHealth, Sutter Health System, University of Maryland Medical System, Henry Ford Health System, Susquehanna Health System, Ministry Health System and Jewish Health System. Mr. Brazitis served as Interim CEO at Doctor's Hospital in Columbus, Ohio. He guided Doctor's through an operational turnaround and profitability. Mr. Brazitis has particular expertise in helping organizations address strategic, financial and operational challenges. Mr. Brazitis' professional experience includes: CEO, Lancaster Regional Health, Lancaster, PA, a two-hospital system with 416 beds, CEO, Lancaster General Hospital, Lancaster, PA, a 520-bed teaching facility with a $300 million budget.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

TOM HONAN
MANAGING DIRECTOR
thonan@navigant.com
727.421.1768

Tom Honan, a Managing Director of Navigant Consulting, has more than 20 years of healthcare experience. He has served as an oversight executive, project director and team member on diverse consulting assignments and held interim management positions in community hospitals and major academic medical centers.

Mr. Honan has assisted Navigant Consulting on more than 80 engagements, serving as the oversight executive on projects for clients such as California Pacific Medical Center in California, Elliot Health System in New Hampshire, Lake Hospital System in Ohio, Morton Plant Mease in Florida, and the Unsecured Creditors Committee of Doctors Community Healthcare Corporation.

Additionally, Tom managed performance improvement plans for clients such as Virginia Commonwealth University Health System in Virginia, UMass Memorial Healthcare in Massachusetts, California Pacific Medical Center in California, St. Francis Hospital and Health Centers in Illinois, St. Joseph Hospital in Georgia, Hillcrest Healthcare System in Oklahoma and Westlake Hospital in Illinois. He has also directed and managed consolidation business plans for Morton Plant Health System and Mease Healthcare in Florida, Novant in North Carolina, California Pacific Medical Center and Davies Medical Center in California, Bon Secours and Christ Hospitals in New Jersey and Henry Ford Cottage Hospital and Bon Secours Hospital in Michigan. Tom has led and managed financial assessments of Beth Israel Hospital in New York and Mt. Sinai Health System in Illinois for the U.S. Department of Housing and Urban Development and prepared a governance and organizational structure study for SUNY Health Science Center at Brooklyn in New York.

Mr. Honan has also held interim management roles as COO and CFO at Detroit Medical Center, CFO at Allegheny Health, CFO at Baptist Health System, CFO at California Pacific Medical Center, and CFO at Brotman Medical Center in Los Angeles, California.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

EDWARD T. WENZKE
MANAGING DIRECTOR
ed.wenzke@navigant.com
847.583.2106

Mr. Wenzke, a Managing Director in the Performance Improvement Practice at Navigant Consulting, has over 25 years of healthcare experience. He has served as an oversight executive, project director and team member on diverse consulting assignments and has held interim management positions in community hospitals and tertiary medical centers.

Prior to his consulting work, Mr. Wenzke served in positions of increasing managerial responsibility, which culminated in his tenure as president and CEO of a hospital system with a combined annual operating budget of $300 million.

For Navigant Consulting, Mr. Wenzke has directed or overseen over 40 engagements involving corporate services, labor effectiveness, performance improvement plan development, physician services, strategic alignment and academic funds flow. He has particular expertise in helping organizations address strategic, financial and operational challenges. His clients include Sentara Healthcare, Virginia, Catholic Health Partners, Ohio, Fairview Health System, Minnesota, Baptist Health Care Corporation, Tennessee, UAB Health System, Alabama, Piedmont Healthcare, Georgia, Catskill Regional Medical Center, New York, University of Arkansas for Medical Sciences, Arkansas and Maimonides Medical Center, New York.

Additionally, Mr. Wenzke has held interim management roles as COO at St. Vincent Catholic Medical Center, CEO at Walker Baptist Hospital , COO for St. Mary's of Michigan, CEO Provena Mercy Hospital and CRO at Catskills Regional Medical Center.

Mr. Wenzke holds a Bachelors Degree in Business Administration from Ohio State and a Masters in Healthcare Administration from Xavier University.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

ROGER E. KAISER, MD
MANAGING DIRECTOR
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813.277.1900

Dr. Roger Kaiser, a Managing Director of Navigant Consulting's healthcare practice, has an impressive clinical, medical education, and management background spanning almost 25 years serving integrated healthcare systems, academic medical centers, ambulatory surgical centers, public, not-for-profit and for-profit organizations. Dr. Kaiser is recognized for his exceptional skills in turnaround and implementation management, strategic positioning, physician collaboration/integration, quality and performance improvement, fiscal management and service growth. His strengths include communications, strategic vision, medical staff development and motivation, and physician support. Dr. Kaiser has participated in a number of engagements since joining Navigant Consulting, in a wide range of interim management and consulting roles including serving in an advisory capacity during the performance improvement project at Martin Luther King Drew Medical Center in Los Angeles, CA. During this role, Dr. Kaiser worked with the Director, Los Angeles County Department Health Services and King Drew's Chief Executive Officer and Chief Medical Officer on issues related to quality and clinical performance improvement, and medical staff redesign in preparation for CMS and JCAHO accreditation. Dr. Kaiser also was a member of the interim management team that led Passiac Beth Israel Hospital (Passiac, NJ) through a successful restructuring and subsequent sale.

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Proprietary and Confidential – Navigant Working Draft

EXHIBIT Q7-4

BIOGRAPHIES AND QUALIFICATIONS OF PRINCIPLE VALUATION

PATRICK J. SIMERS
EXECUTIVE VICE PRESIDENT

EXPERIENCE

Mr. Simers has extensive experience in serving the valuation needs of the health-care industry. He has valued all tangible and intangible assets associated with health-care enterprises, including the capital stock of majority and minority share holdings; medical specialty and physician joint ventures; fee simple, leased fee, and leasehold interests in real estate for hospital systems, stand-alone hospital campuses, and medical office buildings; major and minor movable equipment; certificates of need; contractual agreements; and preferred provider arrangements.

Specific healthcare enterprises appraised include acute care hospital facilities, LTACH hospitals, psychiatric hospitals, rehab hospital facilities, single physician practices, multi-specialty practices, cath labs, diagnostic centers, cardiac care practices, home health agencies, nursing homes, assisted living facilities, and medical office buildings.

Mr. Simers has performed fair market value studies for purchase, sale, or financing; merger and acquisition consulting; negotiation of purchase price; fairness opinions; purchase price allocations; financial reporting; SEC reporting; Medicare regulatory requirements; Safe Harbor requirements; and 501(c)(3) private placement offerings.

PROFESSIONAL HISTORY

Mr. Simers began his appraisal career with Valuation Counselors in 1982 and held various consulting, business development, and management roles, including four years as president of Valuation Counselors, leading up to its merger with CBIZ Inc. Most recently, Mr. Simers has served as the National Director for Healthcare services for American Appraisal Associates where he spear-headed the development of healthcare services for this international appraisal firm.

Patrick J. Simers is Executive Vice President for Principle Valuation. He is responsible for the development and overall business plan for Principle's consulting and appraisal services to for-profit, nonprofit, and public health-care providers. Mr. Simers is located in Principle Valuation's Atlanta office.

PROFESSIONAL AFFILIATIONS

- American Health Lawyers Association
- Healthcare Financial Management Association

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Northern Illinois University with a Bachelor of Science in Finance and Economics
- Graduate of Moraine Valley College with an Associate in Arts in Business Administration
- Certified General Real Estate Appraiser in Georgia
- Certified General Real Estate Appraiser in Florida (#RZ3581)

SALLY M. DOMIJAN

EXPERIENCE

Ms. Domijan has experience in the valuation of business enterprises, majority and minority capital stock interests in privately held companies, intangible assets, preferred stock, restricted stock, and options. In addition she has completed valuations for acquisitions, corporate planning, financial accounting, employee stock ownership plans, fairness opinions, divorce litigation, possible sale, and estate planning purposes.

She has experience valuing a variety of business assets including: trade names, assembled workforce, computer software, medical records, Certificates of Need, noncompete agreements, and specific technologies. She has specialized experience in performing healthcare valuations, including those for hospital systems, ambulatory surgical centers, diagnostic imaging centers, physician practices, clinical labs, healthcare information systems, inpatient and outpatient rehabilitation centers, dialysis centers, home health agencies, medical device companies, HMOs/PPOs, and medical supply companies.

PROFESSIONAL HISTORY

Ms. Domijan is in the Financial Valuation department for Principle Valuation. She has over 20 years in the valuation industry, formerly as a Director of Financial Valuations with American Appraisal, as Director of Financial Valuations with L.T. Annum Appraisal Services, Inc., and a Manager at CBIZ Valuation Group (formerly Valuation Counselors). Prior to that she was a financial analyst in the savings and loan industry.

PROFESSIONAL AFFILIATIONS

- CFA Institute
- CFA Society, Chicago

EDUCATION LICENSES, AND DESIGNATIONS

- University of Illinois at Chicago, Master of Business Administration with a specialization in finance and economics
- Miami University, Oxford, Ohio, Bachelor of Science with a concentration in accounting and finance
- Chartered Financial Analyst

TESTIMONY

- Ms. Domijan has presented testimony as an expert witness in Divorce Court in Cook County. Ms. Domijan has been deposed on valuation matters.

BRIAN O. SPILLERS

EXPERIENCE

Mr. Spillers has been engaged in the advisory, consulting and valuation profession since 1995. His experience has focused on the healthcare industry, and he has performed consulting and valuation assignments involving a variety of assets, including senior living properties, healthcare facilities, and professional office properties. These assignments have included project development, financing, acquisition advisory and integration, divestiture, work-out and turn-around studies for financially distressed properties, data gathering tools, industry research, regulatory approvals and reimbursement purposes.

His experience includes the estimation of market, fee-simple, investment, leasehold and leased fee values covering various assets, focused primarily on healthcare enterprises, and including acute and rehabilitation hospitals, nursing facilities, psychiatric facilities, retirement communities and assisted-living residences.

In the healthcare and senior housing industry, Mr. Spillers has developed detailed market analysis to examine the potential market feasibility of proposed projects. These market assessments include the definition of a primary market area, detailed service analysis, detailed analysis of demographic characteristics and the estimation of demand in the defined primary market area, and have been utilized in connection with proposed healthcare projects as well as projects encountering difficulty with absorption for various financial institutions and healthcare providers.

PROFESSIONAL HISTORY

Mr. Spillers has worked with Principle Valuation, LLC since 2007. Previously, he has been employed by several national healthcare consulting firms. He also served as a contract negotiator with a New York based international financial services firm.

EDUCATION LICENSES, AND DESIGNATIONS

- A graduate of Saint Joseph's University, with a bachelor of science degree in Finance
- New Jersey Certified General Appraiser's license (42RG00220200)

Mr. Spillers has also attended numerous national and regional finance, regulatory and healthcare conventions.

EXHIBIT Q7-5

FAIRNESS EVALUATION PREPARED PRINCIPLE VLAUATION, LLC AND SUPPORTING SCHEDULES

Principle Valuation, LLC
PEOPLE AND VALUES YOU CAN TRUST

October 20, 2015

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Attention: Ms. Darlene Stromstad, FACHE

Re: Fairness Opinion for Conversion of Greater Waterbury Health Network, Inc.

Ladies and Gentlemen:

Pursuant to the Asset Purchase Agreement (Draft dated August 26, 2015), Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will contribute substantially all of their operating assets ("Assets") to a Prospect Affiliate ("Purchaser"), with Prospect Medical Holdings, Inc. ("Prospect Medical", "PMH") as indirect owner.

Pursuant to the proposed Transaction the Board of GWHN has asked Principle Valuation to provide the Board a fairness evaluation of the Transaction to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 19a-486 et seq. ("Conversion Statute"). The date of our analysis is September 1, 2015 giving consideration to historical data available as of June 30, 2015 and subsequent financial data provided to us by the GWHN and their financial consultants.

KEY ELEMENTS OF THE TRANSACTION

We have included the draft of the Asset Purchase Agreement provided to us in the Addenda of this report. Key elements of the Transaction include the following:

- Prospect Affiliate will purchase GWHN's Assets (inclusive of approximately $6,800,000 of net working capital assets) for $45,000,000;
- Prospect Affiliate will assume $14,970,635 of Liabilities from GWHN which will be credited from the cash payments to GWHN;
- Prospect Affiliate will assume the actuarial shortfall on the nurses pension;
- Prospect Affiliate will make a commitment to expend $55,000,000 in capital or other approved commitments for the development and improvement of the hospital, ambulatory or other health care services in the greater Waterbury, CT community over a seven year time frame.

- Seller has the right, if the Buyer sells the Hospital's Business for cash within the first three years of the transaction, to receive 20% of the difference between the cash purchase price paid and the Net Hospital Value.

The Asset Purchase Agreement includes additional understandings and terms not directly related to the financial aspects of the transaction. While we recognize that all parties to the Transaction anticipate that the transaction will enhance the quality and access to healthcare in the community, these factors are difficult to quantify economically and have only been incidentally factored into our conclusions.

SCOPE

In determining whether the consideration is fair from a financial point of view, we have compared the financial rights and responsibilities that currently are held by GWHN with the proposed sales terms. In arriving at the opinion set forth below, we have among other things:

- Visited the Waterbury Hospital Site to describe and assess the overall condition of the physical assets and improvements (Inspections occurred in November 2011 and July 2014). We assumed similar conditions at the facility as of the current analysis;
- Reviewed and relied upon certain information contained in the Confidential Information Memorandum ("CIM") prepared by Cain Brothers in September 2012, and relied upon subsequent representations by Cain Brothers as to their subsequent efforts that were used to solicit other offers of interest for GWHN;
- Been provided and reviewed certain available business and financial information relating to the GWHN that was provided by GWHN's management team and produced subsequent to the CIM, including audited financial statements for the fiscal years ended September 30, 2011 through September 30, 2014 and internally prepared financial statements for the nine months ended June 30, 2015;
- Been provided and relied upon income statement estimates for the fiscal years 2016 through 2018 prepared by GWHN showing GWHN as a Stand-Alone organization if the transaction does not occur;
- Reviewed the prior offers for the subject property over the past several years;
- Reviewed the initial offer outlines by Prospect Affiliate;
- Considered the criteria set forth in the Conversion Statute;
- Interviewed members of GWHN's management;
- Reviewed the Draft Asset Purchase Agreement by and among Greater Waterbury Health Network, Inc. and Buyer dated August 26, 2015;
- Reviewed minutes of the Board of Directors of GWHN for the period February 14, 2013 through August 13, 2015, including the 2014 and 2015 annual meeting minutes; the Waterbury Hospital Joint Task Force meeting minutes of October 17, 2012, July 8, 2013, March 27, 2014, June 26, 2014, August 18, 2014, December

18, 2014, February 12, 2015, March 13, 2015, April 23, 2015, September 10, 2015; and the special board meeting minutes of October 18, 2012, October 25, 2012, April 16, 2015, and April 29, 2015;

- Reviewed the minutes of the Finance Committee for the period May 6, 2014, June 10, 2014, and monthly from the period January 6, 2015 through August 4, 2015;
- Reviewed the Company information and financial information concerning Prospect Medical;
- Reviewed such other financial studies and analysis and took into account such other matters as we deemed necessary, including our assessment of general economic market and monetary conditions.
- Reviewed the historical market prices, trading activity and valuation multiples of certain publicly traded companies that we deemed to be relevant and used them as benchmarks to estimate relative criteria in our analysis; and
- Compared the proposed financial terms of the proposed purchase with certain other transactions that we deemed relevant.

In preparing our opinion, we have assumed and relied on the accuracy and completeness of all information supplied or otherwise made available to us, discussed with or reviewed by or for us, or publically available, and we have not assumed any responsibility for independently verifying such information. Nor have we evaluated the solvency or fair value of GWHN under any state or federal laws relating to bankruptcy, insolvency, or similar matters. The Asset Purchase Agreement speaks to specific remedies and obligations based upon future potential events occurring. In deriving our opinion, to the extent reasonably possible, we have considered the financial impact of these events and their overall impact on the consideration offered.

We have made a physical visit to the Waterbury Hospital and have assessed the contributory value of the depreciated replacement cost of the fixed assets currently present at the site. The inspections occurred in November 2011 and July 2014. We assumed similar conditions at the facility as of the current analysis. With respect to the financial forecast provided to or discussed with us by representatives of GWHN, we have assumed that they have been reasonably prepared and reflect the best currently available estimates and judgment of GWHN as to the expected future financial performance of the Hospital. We have also assumed that the final form of the Asset Purchase Agreement presented to us will be substantially similar to the draft reviewed by us dated August 26, 2015.

We understand the parties have agreed that the Children's Center of Greater Waterbury Health Network, Inc. and Healthcare Alliance Insurance Company, Ltd. are not included in the transaction and have incorporated that in our analysis.

Our opinion is necessarily based upon market, economic and other conditions as they exist and can be evaluated, and on the information made available to us as of the date hereof. We have assumed that there are no undisclosed or unexpected conditions that would affect the value of GWHN's assets or the financial condition or operations of GWHN or the expected future financial performance of GWHN. We have assumed that that in the course of obtaining the necessary

regulatory or other consents or approvals (contractual or otherwise) for the Transaction, no restrictions, including any amendment or modifications, will be imposed that will have a material adverse effect on the transaction.

In connection with the preparation of this opinion, we have not been authorized by GWHN to solicit, nor have we solicited, third-party indications of interest for the acquisition of GWHN's interest.

We are not acting as a financial advisor to any party in this arrangement. Our fees for this engagement are not at all dependent upon the opinion rendered. We have performed work for GWHN in the past in a similar role associated with a failed transaction. GWHN has agreed to indemnify us for certain liabilities arising out of our engagement.

USE

These valuation-consulting services are intended to assist the Board in meeting its fiduciary duties and obligations under the Conversion Statute. Our work is not intended to establish specific pricing recommendations; rather, it is designed to provide the Board with relevant data that will allow it to make an informed decision. Our opinion does not constitute a recommendation regarding the proposed transaction, or any matter related thereto.

We understand that the report may be requested by Connecticut's Attorney General in his overall assessment of the transaction and that we may be required to respond to some of his inquiries about our overall analysis.

CONCLUSIONS

We understand that under the Conversion Statute, the Attorney General shall deny an application as not in the public interest if the Attorney General determines that one or more of the following conditions exist and, as requested by GWHN, we respond to these criteria below to the best of our knowledge and expertise:

(1) The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities;

Please note that we are not admitted to practice law in Connecticut and are not qualified to make this opinion. GWHN and its Transaction attorney have indicated to us that there is no absolute prohibition of the Transaction by Connecticut statutory or common law governing nonprofit entities, trusts or charities, other than that the requirements of the Conversion Statute must be satisfied.

(2) the nonprofit hospital failed to exercise due diligence in (A) deciding to transfer, (B) selecting the purchaser, (C) obtaining a fairness evaluation from an independent person expert in such agreements, or (D) negotiating the terms and conditions of the transfer;

Having reviewed the minutes of the Board and the task force and speaking with GWHN's management, counsel and financial advisors, we find that the Board has exercised due diligence

in deciding to transfer, selecting Prospect Affiliate as the purchaser, and negotiating the terms and conditions of the transfer.

This firm responded to an RFP issued by GWHN, provided its qualifications and was chosen after review of those qualifications and an interview. Principle Valuation, Inc. is independent; it is being paid a flat non-contingent fee for its work on the Transaction.

(3) the nonprofit hospital failed to disclose any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of the hospital, the purchaser or any other party to the transaction;

We are aware that GWHN circulated and received responses to queries of its board members, officers, key employees and experts as well as those of the purchaser with respect to conflicts of interest. While we have not conducted any review in this regard, we are not aware of any undisclosed conflict of interest.

(4) the nonprofit hospital will not receive fair market value for its assets, which, for purposes of this subsection, means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market;

On the basis of and subject to the foregoing, we are of the opinion that, as of September 1, 2015, the Consideration set forth in the Transaction is fair from a financial point of view to the GWHN.

(5) the fair market value of the assets has been manipulated by any person in a manner that causes the value of the assets to decrease;

As noted previously, we have performed reviews of GWHN's financials and assets and find no indication that the fair market value of its assets has been manipulated by any person in a manner that causes the value of the assets to decrease.

(6) the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk;

The Transaction does not encumber GWHN with any financing for the completion of this transaction; consequently, there is no financing of the proposed transaction that would place the nonprofit hospital's assets at an unreasonable risk upon completion of the Transaction.

(7) any management contract contemplated under the transaction is not for reasonable fair value;

We have not reviewed any potential management contracts contemplated under the transaction.

(8) a sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the superior court for the judicial district where the nonprofit hospital is located who are not affiliated through

corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor;

Based on the materials and interviews referenced in this letter and our review of the proposed plans for a post conversion foundation, (a) the fair market value of GWHN's assets will be received and (b) the existing Waterbury Hospital will continue to operate for the support and promotion of health care generally in the hospital's service area. GWHN and its Transaction Attorney have indicated to us that the restricted assets will be used for purposes consistent with the intent of their donors. Principle Valuation has conducted no investigation into the source, limitations, or value of the restricted use assets.

(9) the nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately.

Principle Valuation is not acting, in any fashion, as an agent of the Transaction; and therefore has no opinion as to whether or not all data and information sufficient to evaluate the proposed transaction has been provided to the Attorney General. GWHN advises us that the Attorney General has not concluded its request for information with respect to the Transaction.

Respectfully submitted,

PRINCIPLE VALUATION, LLC

Principle Valuation LLC

PV15.1672

Principle Valuation, LLC

People and Values you can Trust

Greater Waterbury Health Network – Qualitative & Quantitative Considerations

Fairness Opinion

September 25, 2015

Introduction And Background

Pursuant to the Asset Purchase Agreement, (draft dated August 26, 2015), Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will sell substantially all of their operating assets ("Assets") to a Prospect Affiliate ("Purchaser"), with Prospect Medical Holdings, Inc. ("Prospect Medical", "PMH") as indirect owner.

Pursuant to the proposed Transaction the Board of GWHN has asked Principle Valuation to provide the Board a fairness evaluation of the Transaction to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 19a-486 et seq. ("Conversion Statute").

The Fairness Opinion will be provided in a separate letter. This document is presented to the Board and Financial Advisors of GWHN as a supplemental document to highlight the overall process and primary assumptions utilized in arriving at our final conclusion. This document is not being specifically prepared to present to the Attorney General ("AG"); it is a high level document that should be reviewed by the Board and its Financial Advisors for accuracy with respect to the historical information contained herein and general agreement as to underlying operating assumptions utilized. Similar schedules or explanations may be required by the AG upon his review of the final Fairness Opinion and the Transaction in general.

In the proposed transaction, Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will sell substantially all of its assets to an Affiliate of Prospect Medical.

Introduction And Background

GWHN has been seeking a capital partner since 2011. Its efforts have been quite exhaustive including consideration of a joint venture Agreement with LHP solely; a successive joint venture arrangement with LHP and St. Mary's which would have developed a new state-of-the-art facility and a single provider for the market; and then a joint venture arrangement with Vanguard/Tenet in 2013. Despite strong efforts to complete each of these transactions; for a variety of different reasons, the partners decided to withdraw from the transactions. During this same period, the economic challenges at the facility have increased with each successive year incurring decreased earnings, staff reductions, and necessary capital improvements were shelved. In order to insure that it could fulfill its healthcare mission and future, the Board has continued to seek a capital partner with the assistance of Cain Brothers. Through this process, including the ventures mentioned above, there have been more than 20 potential purchasers canvassed to invest in the operation since 2011. In April, 2015, Prospect Medical Holdings Inc. made an offer substantially similar to the Vanguard/Tenet offer and the Board has asked Principle Valuation to assess its financial fairness.

Prospect Medical Holdings is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates thirteen 13 acute care and behavioral hospitals located in Rhode Island, Texas and California. Overall, PMH operates 2,258 licensed beds. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 260,000 patients in Southern California, South Central Texas and Rhode Island through a network of approximately 8,900 physicians.

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Outline of Proposed Transaction

In the proposed transaction, Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will sell substantially all of their assets to a Prospect Affiliate.

Prospect Affiliate is indirectly owned by Prospect Medical Holdings, Inc. ("Prospect Medical"). Prospect Medical is a provider of healthcare services through its hospitals, clinics, and physician networks. It currently owns 13 hospitals in three states including Southern California, South Central Texas, and Rhode Island.

Key elements of the transaction are as follows:

- Prospect Affiliate will purchase GWHN's Assets (inclusive of approximately $6,800,000 of net working capital assets) for $45,000,000;
- Prospect Affiliate will assume $14,970,635 of Liabilities from GWHN which will be credited from the cash payments to GWHN;
- Prospect Affiliate will assume the actuarial shortfall on the nurses pension;
- Prospect Affiliate will make a commitment to expend $55,000,000 in capital or other approved commitments for the development and improvement of the hospital, ambulatory or other health cares services in the greater Waterbury, CT community over a seven year time frame;
- Seller has the right, if the Buyer sells the Hospital's Business for cash within the first three years of the transaction, to receive 20% of the difference between the cash purchase price paid and the Net Hospital Value.

00836

Assets Anticipated to Transfer

GWHN will transfer substantially all of its operating assets or equity interests in its affiliates to Prospect Affiliate. This would include all the tangible and intangible assets currently utilized in the hospital's operations. Tangible assets would include a net working capital balance of approximately $6,800,000, inventories, prepaid insurance, other prepaid expenses, the real estate and equipment. Intangible assets would included all of the ownership interests held in the affiliate companies (other than the Children's Center of Greater Waterbury Health Network, Inc. and Healthcare Alliance Insurance Company, Ltd.), the operating licenses, contracts, tradenames, trademark, web sites, etc. All assets will be transferred essentially free and clear of any encumbrances.

The legacy hospital entity will maintain Cash and Cash Equivalents, Short-Term Investments, Assets Due From Affiliates, Noncurrent Assets Who Use is Limited and Funds Held in Trust by Others. It will also maintain a portion of Net Accounts Receivable, Accounts Receivable Other Prepaid Insurance and Other Expenses, and Net PP&E. The legacy hospital entity will remain responsible for payments Due to Third Party Payors, Long-Term Debt, Workers Compensation, Malpractice, and Other Long-term Liabilities. It will maintain a portion of Accounts Payable. These accounts are detailed on the following schedules.

As contemplated, $19,338,842 of cash will be delivered to GWHN at closing. The legacy hospital entity will be responsible for addressing the liabilities at and after closing.

The Net Proceeds Calculation prepared by Management is presented on the following schedules.

Net Proceeds Calculation Prepared By Management

	Balance Sheet as of 6/30/2015 (Ownership Adjusted)	Pro Forma	
		Retained by Surviving Entity	Purchased/ Assumed by Prospect
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 19,594,297	$ 19,594,297	$ -
Short-term Investments	$ 1,546,952	$ 1,546,952	$ -
Net Accounts Receivable	$ 35,489,960	$ 128,166	$ 35,361,793
Accts Receivable - Other	$ 4,141,299	$ 3,753,101	$ 388,198
Inventories	$ 4,004,633	$ -	$ 4,004,633
Prepaid Insurance and Other Expenses	$ 3,867,336	$ 1,415,103	$ 2,452,234
Due From Affiliates	$ 684,423	$ 684,423	$ -
Total Current Assets	$ 69,328,900	$ 27,122,042	$ 42,206,858
Noncurrent Assets Who Use Is Limited:			
CHEFA Bond Issue Cost	$ 304,391	$ 304,391	$ -
Investments	$ 27,283,068	$ 27,283,068	$ -
Board Designated Funds	$ 3,335,566	$ 3,335,566	$ -
Loans and Other Receivables	$ 207,606	$ 207,606	$ -
Funds Held in Trust by Others	$ 45,948,228	$ 45,948,228	$ -
Goodwill	$ 1,813,567	$ -	$ 1,813,567
Net PP&E	$ 32,549,045	$ 2,019,190	$ 30,529,855
Total Assets	**$ 180,770,372**	**$ 106,220,092**	**$ 74,550,280**

Net Proceeds Calculation Prepared By Management

	Balance Sheet as of 6/30/2015 (Ownership Adjusted)	Pro Forma	
		Retained by Surviving Entity	Purchased/ Assumed by Prospect
Liabilities			
Current Liabilities			
Accounts Payable and Accrued Expenses	$ (22,804,373.65)	$ (2,851,357)	$ (19,953,016.23)
Current Portion of Accrued Pension Liability	$ (3,388,000)	$ -	$ (3,388,000)
Current Portion of Long Term Debt	$ (950,926)	$ (570,943)	$ (379,982)
Due to Third-Party Payors	$ (7,912,485)	$ (7,912,485)	$ -
Total Current Liabilities	$ (35,055,784)	$ (11,334,785)	$ (23,720,999)
Long-Term Debt	$ (24,890,080)	$ (24,918,725)	$ 28,645
Other Long-Term Liabilities:			
Workers Compensation	$ (12,417,149)	$ (12,417,149)	$ -
Pension	$ (8,429,374)	$ -	$ (8,429,374)
Malpractice	$ (1,962,990)	$ (1,962,990)	$ -
Asbestos Abatement	$ (2,801,923)	$ -	$ (2,801,923)
Other Long-Term Liabilities	$ (2,082,328)	$ (2,082,328)	$ -
Total Other Liabilities	$ (52,583,844)	$ (41,381,191)	$ (11,202,653)
Total Liabilities	**$ (87,639,628)**	**$ (52,715,977)**	**$ (34,923,651)**
Net Assets	$ 93,130,744	$ 53,504,115	$ 39,626,629
Net Balance Sheet Items	**$ 180,770,372**	**$ 106,220,092**	**$ 74,550,280**

Net Proceeds Calculation Prepared By Management

Foundation Asset Adjustments

Deal Terms		
Enterprise Value	$	45,000,000
Balance Sheet Liabilities Assumed by Prospect	$	(14,970,635)
Nurses Pension (Asset Shortfall)	$	(15,900,000)
Prospect Proposed Pension Rate Change	$	(7,000,000)
Additional Capital Leases Assumed by Prospect	$	(3,120,018)
Working Capital Adjustment	$	15,329,495
Cash Proceeds Received at Closing	$	19,338,842
Foundation Cash Needs at Closing		
Malpractice Tail Insurance and LPT Expense	$	(7,722,530)
Estimated Transaction Costs	$	(2,650,000)
Contingencies	$	(1,000,000)
Total Cash Needs at Closing	$	(11,372,530)
Net Cash Proceeds to Foundation	$	7,966,312
Net Asset Calculation		
Net Foundation Assets Before Adjustments	$	53,504,115
Write-off of Other Assets	$	(1,415,103)
Net Cash Proceeds to Foundation	$	7,966,312
Net Assets at Closing	$	60,055,325

00840

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion

In deriving our "Fairness Opinion", we considered the value of the assets transferred against the value of the benefits to be received from a financial point of view. While we recognize that all parties to the Transaction anticipate that the transaction will enhance the quality and access to healthcare in the community, these factors are difficult to quantify economically and have only been incidentally factored into our conclusions.

In assessing the value of the assets transferred we considered the three traditional valuation methodologies: the Cost Approach, Market Approach, and Income Approach.

In assessing the value of the benefits received by the Transaction, we considered the cash benefits received to the post conversion foundation and the value of the assumed liabilities transferred to Prospect Medical.

00841

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion - Continued

In deriving our "Fairness Opinion" we have among other things:

- Visited the Waterbury Hospital site to describe and assess the overall condition of the physical assets and improvements. (Inspections occurred in November 2011 and July 2014). We assumed similar conditions at the facility as of the current analysis;
- Reviewed and relied upon certain information contained in the Confidential Information Memorandum ("CIM") prepared by Cain Brothers in September 2012, and relied upon subsequent representations by Cain Brothers as to their subsequent efforts that were used to solicit other offers of interest for GWHN;
- Been provided and reviewed certain available business and financial information relating to GWHN that was provided by GWHN's management team and produced subsequent to the CIM, including audited financial statements for the fiscal years ended September 30, 2011 through September 30, 2014 and internally prepared financial statements for the nine months ended June 30, 2015;
- Been provided with and relied upon income statement estimates for the fiscal years 2016 through 2018 prepared by GWHN showing GWHN as a Stand-Alone organization if the transaction does not occur;
- Reviewed prior offers for the subject property over the past several years;
- Reviewed the initial offer outlines by Prospect Affiliate;
- Considered the criteria set forth in the Conversion Statute;

(Continued)

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion - Continued

In deriving our "Fairness Opinion" we have among other things (continued):

- Interviewed members of GWHN's management;
- Reviewed the Draft Asset Purchase Agreement by and among Greater Waterbury Health Network, Inc. and Buyer dated August 26, 2015;
- Reviewed minutes of the Board of Directors of GWHN for the period February 14, 2013 through August 13, 2015, including the 2014 and 2015 annual meeting minutes; the Waterbury Hospital Joint Task Force meeting minutes of October 17, 2012, July 8, 2013, March 27, 2014, June 26, 2014, August 18, 2014, December 18, 2014, February 12, 2015, March 13, 2015, April 23, 2015, September 10, 2015; and the special board meeting minutes of October 18, 2012, October 25, 2012, April 16, 2015, and April 29, 2015;
- Reviewed minutes of the Finance Committee for the period May 6, 2014, June 10, 2014, and monthly from the period January 6, 2015 through August 4, 2015;
- Reviewed the Company information and financial information concerning Prospect Medical;
- Reviewed such other financial studies and analysis and took into account such other matters as we deemed necessary, including our assessment of general economic market and monetary conditions;
- Reviewed the historical market prices, trading activity and valuation multiples of certain publicly traded companies that we deemed to be relevant and used them as benchmarks to estimate relative criteria in our analysis.

Critical Facts and Assumptions

The following critical facts and assumptions among other factors were considered in deriving our overall estimates:

- GWHN is one of two primary healthcare providers in the Greater Waterbury market area;
- In the absence of this transaction, GWHN will face increased competition from St. Mary's and other nearby hospitals and systems;
- Waterbury's physical plant is approaching the end of its economic life and needs renovation within the next five to seven year period. Based upon a physical inspection, discussions with management, and the actual age and condition of the property, we have assigned a remaining economic life for the Waterbury Campus of five years in the absence of an alternative capital resource partner;
- It is anticipated by management that GWHN's earnings will continue to deteriorate due to the increased competition, lower volumes and costs associated with its physical plant to the point that the overall business operations will generate marginal to negative cash flows;
- In the absence of this Transaction and in consideration of the factors stated above, the overall economic viability of the organization and its ability to continue its healthcare mission in the foreseeable future is limited.

00844

Valuation of Assets Contributed - Overview

In deriving the value of the assets to be contributed to Prospect Medical, we considered the three principal methods of valuation: the Cost Approach (Adjusted Book Value Approach), the Market Approach, and the Income Approach. Each Approach as applied to GWHN is briefly explained below:

- In the Cost Approach, the tangible assets of GWHN were valued by deriving a depreciated replacement cost for the tangible assets in use. The land was valued at its current value assuming current market data. The Net Working Capital was valued based upon the stated value on the Balance Sheets provided. A Summary of this Approach is shown on Schedule 1A.

- In the Income Approach to Value, we considered the value of GWHN utilizing a Discounted Cash Flow approach based upon market based cost of capital considerations and the anticipated limited earning capacity of GWHN in a "Stand-Still" strategic choice. This analysis is shown in Schedule 1B.

- We considered two Market Based approaches in estimating the value of the subject; Guideline Company Approach and Guideline Transaction Approaches to value. These approaches are shown on Schedules 1C and 1D, respectively.

After considering the strengths and weakness of each approach, we derived an overall weighted value for the assets contributed.

Schedule 1A – Cost Approach Summary

WATERBURY HOSPITAL - SCHEDULE 1A

VALUATION SUMMARY AS OF JUNE 2015 WITH ECONOMIC DEPRECIATION

Building/Name	Address	Land Value	Building Depreciated Cost	Land Improvements Replacement Cost	Land Improvements Depreciated Cost	Total Real Estate Value	FF&E	Grand Total
Waterbury Hospital		$ 7,500,000	$ 2,389,000	$ 3,635,718	$ 41,000	$ 9,930,000	$1,517,000	$ 11,447,000
Grandview Building		-	76,000	-	-	76,000	-	76,000
Apartment A & B		-	16,000	-	-	16,000	-	16,000
Baker House		-	15,000	-	-	15,000	-	15,000
72 Hale Street		-	45,000	-	-	45,000	-	45,000
101 Robbins Street		-	21,000	-	-	21,000	-	21,000
36 Grandview Avenue		-	22,000	-	-	22,000	-	22,000
140 Grandview Avenue Suites		-	64,000	-	-	64,000	-	64,000
134 Grandview Avenue Suites		-	39,000	-	-	39,000	-	39,000
TOTALS		$ 7,500,000	$ 2,687,000	$ 3,635,718	$ 41,000	$ 10,228,000	$ 1,517,000	$ 11,745,000

Tangible Asset Value Summary

Working Capital	$ 6,800,000
Land	7,500,000
Land Improvements	41,000
Buildings	2,687,000
Equipment	1,517,000
Total Tangible Assets	$ 18,545,000
Rounded To	$ 18,550,000

00846

Schedule 1B – DCF Stand Still

Discounted Cash Flow GWHN "Stand-Still" - Schedule 1B

		Fiscal Year Ended September 30, FY 2013	FY 2014	Trailing Twelve Months 6/30/2015	FY 2016 Projected	FY 2017 Projected	FY 2018 Projected	FY 2019 Projected	FY 2020 Projected
NET PATIENT REVENUE									
Net Patient Service Revenues		$ 259,397,257	$ 253,394,006	$ 247,217,460	$ 255,217,792	$ 258,488,857	$ 260,749,204	$ 267,267,934	$ 273,949,632
Provision for Bad Debts		(11,368,671)	(4,454,817)	(3,206,224)	(3,948,763)	(4,000,648)	(4,030,001)	(4,130,751)	(4,234,020)
Total Net Patient Service Rev Less Bad Debts		248,028,586	248,939,189	244,011,236	251,269,029	254,488,209	256,719,202	263,137,183	269,715,612
Other Operating Revenue		4,725,959	4,483,138	5,762,534	14,643,067	14,825,462	14,878,373	15,250,332	15,631,591
Revenue from Operations		$ 252,754,545	$ 253,422,327	$ 249,773,770	$ 265,912,096	$ 269,313,671	$ 271,597,575	$ 278,387,515	$ 285,347,203
Growth			0.3%		6.5%	1.3%	0.8%	2.5%	2.5%
OPERATING EXPENSES									
Salaries, Wages, and Benefits	v	$ 152,117,220	$ 151,760,190	$ 157,123,840	$ 156,423,303	$ 159,589,217	$ 162,790,793	$ 164,248,634	$ 168,354,850
Supplies, Utilities, and Other	f	101,697,631	107,222,243	103,231,324	108,173,646	108,245,192	108,782,377	111,501,936	114,289,485
Subtotal		253,814,851	258,982,433	260,355,164	264,596,949	267,834,410	271,573,170	275,750,570	282,644,334
Depreciation/Amortization	f	8,996,581	7,991,436	7,393,894	6,849,701	6,838,400	6,830,365	7,001,124	7,176,152
Interest Expense	f	1,125,827	1,476,326	1,435,535	1,353,599	1,353,349	1,353,349	1,387,183	1,421,862
Total Operating Expense		$ 263,937,259	$ 268,450,195	$ 269,184,593	$ 272,800,249	$ 276,026,159	$ 279,756,884	$ 284,138,877	$ 291,242,349
Gain/(Loss) from Operations		$ (11,182,714)	$ (15,027,868)	$ (19,410,823)	$ (6,888,153)	$ (6,712,488)	$ (8,159,309)	$ (5,751,362)	$ (5,895,146)
Total Non-Operating Income(2)		7,988,488	8,497,993	6,634,714	8,407,685	8,433,432	8,460,337	8,671,846	8,888,642
Excess of revenue over expenses		$ (3,194,226)	$ (6,529,875)	$ (12,776,109)	$ 1,519,532	$ 1,720,944	$ 301,029	$ 2,920,484	$ 2,993,496
EBITDA (excluded non-operating income)		$ (1,060,306)	$ (5,560,106)	$ (10,581,394)	$ 1,315,147	$ 1,479,262	$ 24,405	$ 2,636,945	$ 2,702,868
EBITDA Margin		*-0.4%*	*-2.2%*	*-4.2%*	*0.5%*	*0.5%*	*0.0%*	*0.9%*	*0.9%*
EBIT		$ (10,056,887)	$ (13,551,542)	$ (17,975,288)	$ (5,534,554)	$ (5,359,138)	$ (6,805,959)	$ (4,364,179)	$ (4,473,284)

Note:
(1) Revenue excludes EHRIT Meaningful Use revenue of the following:
$ 2,277,750 $ 1,507,510
(2) Net Assets Released from Restrictions is shown in Total Non-Operating Income

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Schedule 1B – DCF Stand Still (Continued)

Discounted Cash Flow GWHN "Stand-Still" - Schedule 1B						
Discount Rate	11.00%					
Effective Corporate Tax Rate in U.S, CT	39.88%					
Normal Debt Free Net Working Capital as % of Revenues	12.00%					
	FY 2016 Projected	FY 2017 Projected	FY 2018 Projected	FY 2019 Projected	FY 2020 Projected	
NET INCOME FOR DISCOUNTING (EBIT)	$ (5,534,554)	$ (5,359,138)	$ (6,805,959)	$ (4,364,179)	$ (4,473,284)	
ESTIMATED INCOME TAXES	(2,207,180)	(2,137,224)	(2,714,217)	(1,740,435)	(1,783,946)	
NET INCOME	**$ (3,327,374)**	**$ (3,221,914)**	**$ (4,091,743)**	**$ (2,623,744)**	**$ (2,689,338)**	
Less Incremental Working Capital	$ (1,498,772)	$ (408,189)	$ (274,068)	$ (814,793)	$ (835,163)	
Less Capital Expenditures	(7,857,143)	(7,857,143)	(7,857,143)	(7,857,143)	(7,857,143)	
Plus Depreciation	6,849,701	6,838,400	6,830,365	7,001,124	7,176,152	
Cash Flow to Discount	$ (5,833,588)	$ (4,648,846)	$ (5,392,589)	$ (4,294,556)	$ (4,205,492)	
Discount Periods	0.500	1.500	2.50	3.50	4.50	
Present Value Factor	0.9492	0.8551	0.7704	0.6940	0.6252	
Present Value of Periodic Cash Flows	$ (5,536,997)	$ (3,975,215)	$ (4,154,224)	$ (2,980,491)	$ (2,629,441)	
Sum of PV Periodic Cash Flows		$ (19,276,368)				
Perpetuity Value	$ 7,700,000					
PV of Perpetuity Value		$ 4,814,346				
Business Enterprise Value Before Adjustments		**$ (14,462,022)**				
Adjustments to Value:						
Less: Market Required Working Capital Balance		$ (29,972,852)				
Add: Working Capital to be Transferred		6,800,000				
Excess/(Deficit) Working Capital		$ (23,172,852)				
Business Enterprise Value After Adjustments		**$ (37,634,874)**				
Rounded Value		$ -				

Schedule 1B – DCF Stand Still (Continued)

DEVELOPMENT OF WACC - GWHN - "Stand-Still"				
			Cost of Capital	% in Capital Structure	Weighted Cost
Debt			**3.22%**	**45%**	**1.45%**
Equity			**16.52%**	**55%**	**9.09%**
Weighted Average Cost of Capital					**10.54%**
Concluded WACC					**11.00%**
Cost of Equity					
Risk Free Rate of Return		2.62%			
Plus Equity Risk Premium					
Market Risk Premium[1]	5.00%				
Times Beta	1.20				
Adjusted Market Risk Premium		6.00%			
Plus Size Premium[2]		5.90%			
Plus Company Specific Risk Premium		2.0%			
Indicated Cost of Equity		**16.52%**			
Cost of Debt					
Concluded Pre-Tax Cost of Debt	5.35%				
Income Tax Rate	39.88%				
Concluded After-Tax Cost of Debt		**3.22%**			
Selected Yields and Interest Rates					
Rates as of 09/01/2015					
Prime Rate			3.25%		
5-Year Treasury Rates			1.49%		
10-Year Treasury Rates			2.17%		
20-year Treasury Rates			2.62%		
Moody's Aaa			4.15%		
Baa			5.35%		

(1) Long-horizon expected equity risk premium recommended by Duff & Phelps 2015 Valuation Handbook
(2)Estimated based on Duff & Phelps 2015 Valuation Handbook - Guide to Cost of Capital

Schedule 1C – Guideline Company Approach – Stand Still
Adjusted Base Year

Guideline Company Approach - Schedule 1C

Company Name	Share Price 9/1/2015	Adjusted Equity Value[1]	Adjusted Enterprise Value	% Debt	Revenues	EBITDA	Debt Free NWC	% Debt Free NWC	Beta	EBITDA Margin	Revenue Multiple	EBITDA Multiple
Universal Health Services Inc. (UHS)	$ 131.78	14,507,396,640	17,873,881,640	19.64%	8,575,803,000	1,549,172,000	588,455,000	6.86%	1.24	18.06%	2.08	11.54
Tenet Healthcare Corp. (THC)	$ 47.34	5,655,804,480	20,624,804,480	74.96%	17,568,000,000	1,888,000,000	2,352,000,000	13.39%	11.54	10.75%	1.17	10.92
Community Health Systems, Inc. (CYH)	$ 51.60	7,316,467,200	25,110,467,200	70.60%	19,491,000,000	2,853,000,000	2,516,000,000	12.91%	1.01	14.64%	1.29	8.80
HCA Holdings, Inc. (HCA)	$ 84.32	42,010,584,960	73,198,584,960	44.92%	38,429,000,000	7,737,000,000	4,357,000,000	11.34%	0.99	20.13%	1.90	9.46
LifePoint Health, Inc. (LPNT)	$ 75.15	4,004,893,800	6,430,793,800	38.37%	4,963,000,000	627,400,000	868,400,000	17.50%	1.16	12.64%	1.30	10.25
HIGH:			$73,198,584,960	74.96%	$38,429,000,000			17.50%	11.54	20.13%	2.08	11.54
LOW:			$6,430,793,800	19.64%	$4,963,000,000			6.86%	0.99	10.75%	1.17	8.80
AVERAGE:				49.70%				12.40%	3.19	15.24%	1.55	10.19
MEDIAN:				44.92%				12.91%	1.16	14.64%	1.30	10.25

(1) Adjusted upward 20% to account for a control premium
(2) Information from Yahoo Finance and SEC annual and quarterly reports.

Waterbury Hospital 0.5%

Qualitative Comparisons (Subject Compared to Market Comparables as a Group)

Unit of Comparison	Status	Adjustment
Size of Company	Inferior	Downward
Diversity of Market Served	Inferior	Downward
EBITDA Margin	Inferior	Downward
Overall Adjustment	Downward	

Waterbury Hospital		
Description	Revenues	EBITDA
Adjustment	-70%	-80%
Adjusted Multiple*	0.389	4.100
Subject Comparable Units	$ 265,912,096	$ 1,315,147
Value Indication	$ 103,366,453	$ 5,392,055
Weighting	40%	60%
Total Asset Value as Unencumbered and assuming market based working capital (Rounded)	$44,600,000	
Market Required Working Capital Balance	$ (29,972,852)	
Actual Working Capital Balance	$ 6,800,000	
Less: Deficient (Excess) Working Capital	$ (23,172,852)	
Business Enterprise Value	$ 21,427,148	
Overall Value Rounded	$ 21,400,000	

Schedule 1D – Guideline Transaction Approach

Transactions of Hospitals with Net Losses

Facility	State	Sale Date	Reported Price	Number of Beds	Revenues	Earnings	Price/Revenue Adjusted (1)	Price/Bed	Earnings Lost/Revenues
Monroe Hospital	IN	10/20/14	$2,000,000	132	$41,936,686	($23,129,002)	0.05	$15,152	-55.2%
Two Kansas Hospitals	KS	3/1/13	$54,300,000	232	$184,802,677	($8,780,678)	0.29	$234,052	-4.8%
Lakeside Women's Hospital	OK	1/1/13	$21,900,000	61	$39,194,023	($5,014,932)	0.56	$359,016	-12.8%
New York Westchester Square Medical Center	NY	12/1/12	$14,000,000	140	$75,679,000	($2,400,000)	0.18	$100,000	-3.2%
New England Sinai Hospital	MA	4/1/12	$37,000,000	212	$74,300,000	($3,700,000)	0.50	$174,528	-5.0%
Christ Hospital	NJ	3/1/12	$43,500,000	227	$125,100,000	($4,600,000)	0.35	$191,630	-3.7%
Satilla Health Services	GA	3/1/12	$51,000,000	231	$152,800,000	($540,000)	0.33	$220,779	-0.4%
Cumberland River Hospital	TN	2/1/12	$6,750,000	36	$11,100,000	($520,000)	0.61	$187,500	-4.7%
Decatur General Hospital	AL	2/1/12	$25,000,000	242	$113,500,000	($1,500,000)	0.22	$103,306	-1.3%
Parkway Medical Center	AL	12/1/11	$37,800,000	109	$45,300,000	($1,500,000)	0.96	$346,789	-3.3%
Virginia Regional Medical Center	MN	12/1/11	$27,000,000	164	$50,700,000	($1,200,000)	0.61	$164,634	-2.4%
Louisiana Medical Center and Heart Hospital	LA	10/3/11	$23,000,000	137	$50,400,000	($37,500,000)	0.52	$167,883	-74.4%
Person Memorial Hospital	NC	6/1/11	$22,700,000	102	$41,600,000	($394,000)	0.63	$222,549	-0.9%
Hospital of Saint Raphael	CT	3/1/11	$135,000,000	511	$450,300,000	($7,200,000)	0.34	$264,188	-1.6%
Two Chicago Suburban Hospitals	IL	8/1/10	$45,000,000	569	$267,372,825	($30,444,778)	0.19	$79,086	-11.4%
Sparks Health System	AR	12/1/09	$138,200,000	510	$258,162,282	($23,592,914)	0.62	$270,980	-9.1%
Banks Jackson Commerce Medical Center	GA	12/1/09	$7,100,000	90	$45,160,355	($818,931)	0.18	$78,889	-1.8%
Medina General Hospital	OH	4/1/09	$50,000,000	118	$88,900,000	($1,300,000)	0.65	$423,729	-1.5%
Wadley Health System	TX	2/1/09	$21,000,000	370	$95,074,879	($8,068,172)	0.25	$56,757	-8.5%
Palmetto Health Baptist Easley	SC	1/1/09	$50,000,000	109	$84,400,000	($4,500,000)	0.68	$458,716	-5.3%
St Francis Hospital & Health Center	IL	7/1/08	$65,000,000	309	$158,171,473	($15,567,027)	0.47	$210,356	-9.8%
Our Lady of Mercy Medical Center	NY	7/1/08	$38,000,000	369	$207,973,604	($9,265,220)	0.21	$102,981	-4.5%
North Ridge Medical Center	FL	4/1/08	$20,000,000	332	$90,484,054	($39,786,982)	0.25	$60,241	-44.0%
Saint Clare's Health System	NJ	4/1/08	$145,800,000	655	$240,552,031	($6,959,774)	0.70	$222,595	-2.9%

(1) Adjusted Pre-2012 Sales Upward by 15% to Account For Bad Debt Reporting Change

Average	**0.43**	**$196,514**	**-11.3%**
Median	**0.41**	**$189,565**	**-4.6%**
High	**0.96**	**$458,716**	**-0.4%**
Low	**0.05**	**$15,152**	**-74.4%**

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Schedule 1D – Guideline Transaction Approach

Greater Waterbury Health Network		
	Revenue	Beds
Projected 2016	$ 265,912,096	357
Selected Multiple	0.20	$ 60,000
Indicated Value	$ 53,182,419	$ 21,420,000
Weighting	50.0%	50.0%
Overall Indication Before Adjustments		**$ 37,300,000**
Plus: Debt-Free Net Working Capital		**$ 6,800,000**
Overall Value Derived (rounded)		**$ 44,100,000**

Summary and Reconciliation of Assets Transferred

In arriving at the value of the assets transferred, we considered four different indicators under the three different appraisal approaches. In determining a final estimate, we weighted each approach giving consideration to the strengths and weakness of each indication. Based upon this weighting, we derived an overall value estimate of $25,400,00 for the assets to be transferred. Based upon a Consideration of $45,000,000 for the assets transferred there is a Net Financial Benefit associated with the asset sale to Prospect Medical. This calculation is shown on the following table.

Greater Waterbury Health Network
Summary and Conclusion of Assets to Transfer

		Indicated Value	Weighting	Weighted Contribution
Adjusted Book Value Approach	Schedule A	$18,550,000	60%	$11,130,000
Discounted Cash Flow Approach	Schedule B	$0	0%	$0
Market Based Approaches				
Guideline Company Approach	Schedule C	$21,400,000	15%	$3,210,000
Guideline Transaction Approach	Schedule D	$44,100,000	25%	$11,025,000
Total Weighted Value of Assets Transferred				**$25,400,000**
Total Consideration Given for Assets Transferred				**$45,000,000**
Net Benefit of Assets Transferred				**$19,600,000**

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Overall Conclusion

The following table summarizes the value of the assets to be contributed and purchased against the benefits that GWHN can reasonably anticipate to achieve given the assumptions and expectations associated with the proposed transaction as contained herein. Based upon a comparison of these economic expectations, it is our conclusion that the transaction is fair from a financial point of view as the value received is greater than the value of the assets purchased.

Greater Waterbury Health Network Summary and Conclusion of Fairness From a Financial Point of View	
Total Weighted Value of Assets Transferred	**$25,400,000**
Total Consideration Given for Assets Transferred	**$45,000,000**
Net Benefit of Assets Transferred	**$19,600,000**
Total Financial Benefit of Transaction	***$19,600,000***

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EXHIBIT Q8-1

PHM FISCAL YEAR 2014 AUDITED FINANCIAL STATEMENTS

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended
September 30, 2014 and 2013

The report accompanying these financial statements was issued by BDO USA, LLP, a Delaware limited liability partnership and the U.S. member of BDO International Limited, a UK company limited by guarantee.

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended September 30, 2014 and 2013

Prospect Medical Holdings, Inc.

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Independent Auditor's Report

Board of Directors
Prospect Medical Holdings, Inc.
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect Medical Holdings, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of income, statements of stockholder's deficit, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect Medical Holdings, Inc. and its subsidiaries as of September 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BDO USA, LLP

December 17, 2014

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Consolidated Financial Statements

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2014	2013
Assets		
Current assets:		
Cash and cash equivalents	$ 39,072	$ 86,315
Restricted cash	4,976	563
Investments, primarily restricted money market funds	642	637
Patient accounts receivable, net of allowance for doubtful accounts of $49,727 and $28,050	123,733	75,606
Due from government payers	42,518	27,408
Other receivables	15,947	8,034
Income taxes receivable, net	57	2,365
Deferred income taxes, net	68,304	8,254
Inventories	10,448	4,679
Hospital fee program receivable	-	18,895
Prepaid expenses and other current assets	14,317	8,967
Total current assets	320,014	241,723
Property, improvements and equipment, net	229,474	126,532
Deferred financing costs, net	9,457	11,625
Deferred income taxes, net	-	6,361
Goodwill	158,864	158,864
Intangible assets, net	35,274	31,325
Other assets	8,234	2,516
Total assets	$ 761,317	$ 578,946

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2014	2013
Liabilities and Stockholder's Deficit		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 39,314	$ 30,352
Accounts payable and other accrued liabilities	88,218	52,151
Accrued salaries, wages and benefits	53,808	30,057
Hospital fee program liability and deferred revenue	2,806	8,609
Due to government payers	26,584	19,634
Income taxes payable, net	5,879	1,288
Revolving line of credit	20,000	-
Current portion of capital leases	4,691	5,429
Current portion of long-term debt	133	178
Other current liabilities	1,659	485
Total current liabilities	243,092	148,183
Long-term debt, net of current portion	421,755	420,889
Deferred income taxes, net	70,447	24,869
Malpractice reserves	4,590	4,660
Capital leases, net of current portion	10,463	11,816
Asset retirement obligations	4,310	-
Other long-term liabilities	7,866	570
Total liabilities	762,523	610,987
Commitments, contingencies and subsequent events		
Stockholder's deficit:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2014 and 2013	1	1
Additional paid-in capital	18,457	15,334
Accumulated deficit	(28,481)	(47,496)
Total stockholder's deficit attributable to Prospect Medical Holdings, Inc.	(10,023)	(32,161)
Non-controlling interests	8,817	120
Total stockholder's deficit	(1,206)	(32,041)
Total liabilities and stockholder's deficit	$ 761,317	$ 578,946

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Income
(in thousands)

For the Years Ended September 30,	2014	2013
Revenues:		
Net Hospital Services revenues	$ 618,956	$ 518,206
Provision for bad debts	(32,945)	(34,067)
Net Hospital Services revenues less provision for bad debts	586,011	484,139
Medical Group revenues	253,980	221,743
Other revenues	14,525	7,700
Total net revenues	854,516	713,582
Operating Expenses:		
Hospital operating expenses	449,742	348,961
Medical Group cost of revenues	185,342	164,457
General and administrative	133,056	99,935
Depreciation and amortization	23,580	16,814
Impairment of intangible assets	-	3,476
Total operating expenses	791,720	633,643
Operating income from unconsolidated joint venture	3,356	2,217
Operating income	66,152	82,156
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	41,437	38,860
Gain on bargain purchase	(4,817)	-
Other expense	419	244
Total other (income) expense, net	37,039	39,104
Income before income taxes	29,113	43,052
Income tax provision	10,561	9,810
Net income	18,552	33,242
Net income attributable to non-controlling interests	(463)	7
Net income attributable to Prospect Medical Holdings, Inc.	$ 19,015	$ 33,235

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Stockholder's Deficit
(in thousands except share amounts)

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Deficit	Non-controlling Interests	Total Stockholder's Deficit
Balance at September 30, 2012	100	$ 1	$ 11,634	$ 19,269	$ 30,904	$ 113	$ 31,017
Options exercised	-	-	105	-	105	-	105
Stock-based compensation	-	-	3,595	-	3,595	-	3,595
Distribution to Ivy Holdings Inc. (Parent)	-	-	-	(100,000)	(100,000)	-	(100,000)
Net income	-	-	-	33,235	33,235	7	33,242
Balance at September 30, 2013	100	1	15,334	(47,496)	(32,161)	120	(32,041)
Stock-based compensation	-	-	2,673	-	2,673	-	2,673
Investment in Chaparral Medical Group (see Note 1)	-	-	450	-	450	-	450
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	9,160	9,160
Net income	-	-	-	19,015	19,015	(463)	18,552
Balance at September 30, 2014	100	$ 1	$ 18,457	$ (28,481)	$ (10,023)	$ 8,817	$ (1,206)

See accompanying notes to the consolidated financial statements.

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Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2014	2013
Operating activities		
Net income	$ 18,552	$ 33,242
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	23,580	16,814
Amortization of deferred financing costs, net	2,218	2,071
Amortization of original issue discount and premium, net	992	1,002
Provision for bad debts	32,945	34,067
Deferred income taxes, net	(8,111)	(340)
Stock-based compensation	2,673	3,595
Income from equity method investments	(178)	-
Impairment of intangible assets	-	3,476
Loss on disposal of assets	-	28
Gain on bargain purchase	(4,817)	-
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(50,596)	(47,956)
Due to/from government payers, net	(8,827)	(14,962)
Prepaid expenses and other current assets	(1,682)	560
Hospital fee program receivable	18,895	14,578
Inventories	(814)	(12)
Hospital fee program liability and deferred revenue	(5,803)	(11,168)
Income taxes payable/receivable, net	6,899	(10,286)
Deposits and other assets	1,338	(960)
Accrued medical claims and other healthcare costs payable	8,962	3,367
Accounts payable and other accrued liabilities	16,177	11,831
Net cash provided by operating activities	52,403	38,947
Investing activities		
Purchases of property, improvements and equipment	(50,107)	(14,283)
Cash paid for acquisitions, net of cash received and working capital adjustments	(58,300)	(3,085)
Cash paid for investment in Chaparral Medical Group, Inc. (see Note 1)	(1,100)	-
Change in note receivable (net)	66	63
Increase in restricted investments	(5)	(3)
Net cash used in investing activities	(109,446)	(17,308)
Financing activities		
Borrowings of 2019 Notes	-	102,000
Borrowings on line of credit, net	20,000	-
Repayments of long-term debt	(176)	(211)
Repayments on SCH Culver City Creditors Trust Note	-	(500)
Repayments of capital leases	(5,435)	(4,370)
Cash paid for deferred financing costs, net	(50)	(3,948)

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows (Continued)
(in thousands)

For the Years Ended September 30,	2014	2013
Change in restricted cash	(2,676)	(300)
Cash paid for lender consent fees - 2019 Notes	-	(8,914)
Distribution to Ivy Holdings Inc. (Parent)	-	(100,000)
Proceeds from exercises of stock options and warrants	-	105
Repayments of insurance premium financing	(1,863)	(1,613)
Net cash provided by (used in) financing activities	9,800	(17,751)
(Decrease) Increase in cash and cash equivalents	(47,243)	3,888
Cash and cash equivalents, beginning of year	86,315	82,427
Cash and cash equivalents, end of year	$ 39,072	$ 86,315
Supplemental disclosure of cash flow information		
Interest paid	$ 37,608	$ 32,435
Income taxes paid, net	$ 12,004	$ 20,438
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 2,028	$ 4,274
Building lease capitalized	$ -	$ 5,675
Tenant improvement allowance	$ -	$ 1,227
Conversion of note payables to capital leases	$ -	$ 804
Insurance premium financed	$ 1,842	$ 1,635
Long-term liability assumed from acquisition of PCC (see Note 4)	$ 6,440	$ -

See accompanying notes to the consolidated financial statements.

1. Organization

Prospect Medical Holdings, Inc. ("Prospect" or the "Company" or the "Parent Entity") is a Delaware corporation and a wholly owned indirect subsidiary of Ivy Holdings Inc. ("Ivy Holdings").

During the year ended September 30, 2013, the Company incorporated Prospect Health Plan, Inc. ("PHP"), a Delaware corporation and a wholly owned indirect subsidiary of Prospect. On November 4, 2014, the California Department of Managed Health Care ("DMHC") approved PHP's application and issued its license to operate as a Knox-Keene Health Care Service Plan for the purpose of managing "plan-to-plan" contracts with fully licensed Medicare Advantage ("MA") health plans. As part of the strategic effort to expand the Company's plan-to-plan global capitation structure into other geographic markets, Prospect Health Services, Inc. ("PHS") and Prospect Health Services RI, Inc. ("PHSRI") were incorporated during the year ended September 30, 2014, in Texas and Rhode Island, respectively. Collectively, PHP, PHS, and PHSRI will become a new segment in Prospect's operations. For the year ended September 30, 2014, PHP, PHS, and PHSRI did not have any operations.

The Company's operations are currently organized into three primary reportable segments: Hospital Services, Medical Group and Corporate, as discussed below.

Hospital Services Segment

The Company owns 13 acute care and behavioral hospitals and extended care facilities in Southern California, the Greater San Antonio, Texas region, and Rhode Island with a total of 2,258 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries, Southern California Healthcare System, Inc. ("SCHS"), Alta Los Angeles Hospitals, Inc. ("Alta Los Angeles Hospitals"), Alta Newport Hospital, Inc., Prospect Hospital Holdings, LLC ("Nix Health"), and Prospect CharterCARE, LLC ("PCC") (collectively, the "Hospital Services segment"). The Hospital Services segment subsidiaries are wholly owned by Prospect, except for PCC, in which Prospect has an 85% interest (see Note 4).

Effective January 1, 2013, the Company merged its Brotman Medical Center subsidiary into its Alta Hollywood Hospitals, Inc. subsidiary. The surviving entity was renamed Southern California Healthcare System, Inc. on June 26, 2013. In connection with the merger, the Company changed the names of the hospitals owned by SCHS to Southern California Hospital at Hollywood ("SCH Hollywood") fka Hollywood Community Hospital, Southern California Hospital at Van Nuys ("SCH Van Nuys") fka Van Nuys Community Hospital, and Southern California Hospital at Culver City ("SCH Culver City") fka Brotman Medical Center.

Effective April 16, 2013, Nix Health acquired Community General Hospital of Dilley, Texas, Inc., through its newly created subsidiary, Nix Community General Hospital, LLC ("Nix CGH"). Nix CGH operates a hospital with 18 licensed beds in the city of Dilley, Texas.

Effective May 6, 2014, Prospect acquired substantially all of the assets and associated real estate of Newport Specialty Hospital ("NSH") through Prospect's newly created subsidiary, Alta Newport Hospital, Inc., and Bellflower Medical Center (subsequently renamed Los Angeles Community Hospital at Bellflower or "LACH Bellflower") through Prospect's subsidiary Alta Los Angeles Hospitals, Inc. NSH, located in Tustin, California, was substantially closed in 2013 except for its pediatric sub-acute unit. LACH Bellflower, located in Bellflower, California, was closed in 2013 and has been non-operational since that time. Prospect intends to fully reopen both facilities, including maintaining the NSH pediatric sub-acute unit.

Effective June 20, 2014, Prospect acquired, through its subsidiary, PCC, substantially all of the assets of CharterCARE Health Partners and its subsidiaries. PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("Roger Williams Medical Center"), Prospect CharterCARE SJHSRI, LLC ("St. Joseph Health Services of Rhode Island"), and Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), which include hospitals, medical centers and assisted living facilities located in Rhode Island with 785 licensed beds (collectively, "CharterCARE"). PCC is 85% owned by Prospect and 15% by CharterCARE Community Board (formerly known as CharterCARE Health Partners).

The Company's three community hospitals in Hollywood, Los Angeles and Norwalk offer a comprehensive range of medical and surgical services, including general acute care hospital services, pediatrics, obstetrics and gynecology, pediatric sub-acute care, general surgery, medical-surgical services, orthopedic surgery, and diagnostic, outpatient, skilled nursing and urgent care services. The Company's psychiatric hospital in Van Nuys provides acute inpatient and outpatient psychiatric services on a voluntary basis. SCH Culver City offers a comprehensive range of inpatient and outpatient services, including general surgery, orthopedic, spine, cardiology, diagnostic outpatient, rehabilitation, psychiatric and detox services. In addition, SCH Culver City has an active emergency room that plays an integral part in providing emergency services to the West Los Angeles area.

Nix Health provides comprehensive service offerings at various locations throughout the greater San Antonio, Texas region. These locations include Nix Medical Center, which provides inpatient acute care, geriatric psychiatry services, and emergency room services, Nix Specialty Health Center, which provides a full range of behavioral health and rehabilitation services for children, adolescents, and adults, and a range of health clinics and provider based clinics throughout San Antonio, Texas, and Nix CGH, which operates an inpatient acute hospital in Dilley, Texas and a medical clinic in Pearsall, Texas. Nix Health also opened a 73-bed behavioral health center during the year ended September 30, 2014, which provides psychiatric emergency services and crisis intervention unit.

CharterCARE provides a comprehensive range of services at both Roger Williams Medical Center and St. Joseph's Health Services Rhode Island as well as multiple levels of elder care at Elmhurst Extended Care.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid (Medi-Cal in California) and other third party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed, prepaid monthly fees known as "capitation" payments. The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with all medical services. Prospect currently manages the provision of prepaid healthcare services for its affiliated physician organizations in Southern California. The network consists of the following physician organizations as of September 30, 2014 (stand alone or individually referred to as, an "Affiliate"):

Prospect Medical Group, Inc. ("PMG")
Prospect Health Source Medical Group, Inc. ("PHS")

Prospect Professional Care Medical Group, Inc. ("PPCM")
Genesis HealthCare of Southern California, Inc. ("Genesis")
Prospect NWOC Medical Group, Inc. ("PNW")
StarCare Medical Group, Inc. ("PSC")
AMVI/Prospect Medical Group ("AMVI/Prospect")
Nuestra Familia Medical Group, Inc. ("Nuestra")
Upland Medical Group, a Professional Medical Group ("UMG")*
Pomona Valley Medical Group, Inc. ("PVMG")*

* PVMG and UMG are collectively referred to as the "ProMed Entities."

These Affiliates are managed by the following two medical management company subsidiaries that are wholly-owned by Prospect:

Prospect Medical Systems, Inc. ("PMS")
ProMed Healthcare Administrators ("PHCA")

All of the Affiliates are wholly-owned by PMG, with the exception of Nuestra, which was 66.95% owned by PMG as of September 30, 2014, and AMVI/Prospect which is a 50/50 Joint Venture between AMVI Care Health Network, Inc. ("AMVI") and PMG. The operations of all of these entities, with the exception of AMVI/Prospect, are consolidated in the accompanying consolidated financial statements. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement described below.

PMG's ownership in Nuestra increased from 62% as of September 30, 2013 to 66.95% as of September 30, 2014. On October 7, 2013, Nuestra repurchased 109 shares from a physician shareholder that left Nuestra's group medical practice for a de minimis purchase price in accordance with Nuestra's Agreement Concerning Shares of the Company dated September 19, 1995. The repurchase increased the share percentage holdings of all remaining shareholders and Prospect's percentage rose to 66.95% as of October 7, 2013.

The AMVI Joint Venture was formed for the sole purpose of combining enrollment in order to meet minimum enrollment levels required for participation in the CalOptima Medicaid (Medi-Cal in California) program in Orange County, California. The joint venture ownership is set at 50/50 to prevent either party from exerting control over the other; however, AMVI's and PMG's businesses are operated autonomously, and enrollees, financial results and cash flows are each separately tracked and recorded. In accordance with the joint venture partnership agreement, profits and losses are not split in accordance with the partnership ownership interest, but rather, are directly tied to the results generated by each separate portion of the business. Separate from any earnings the Company generates from PMG's portion of business within the joint venture, the Company also earns fees for management services PMS provides to PMG's partner in the joint venture. The Company accounts for PMG's interest in the joint venture partnership using the equity method of accounting. The Company includes in the consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to the Company, together with the management fee that PMS charges for managing those enrollees specifically assigned to the other joint venture partner.

PMS has entered into an assignable option agreement with PMG and the nominee physician shareholder of PMG. Under the assignable option agreement, Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion. The Company may also assign the assignable option agreement to any person. The assignable option agreement has an initial term of 30 years and is

automatically extended for additional terms of 10 years each, as long as the term of the related management services agreement described below (the "Management Agreement") is automatically extended. Upon termination of the Management Agreement with PMG, the related Stock Option would be automatically and immediately exercised. The Stock Option may be exercised for a purchase price of $1,000. Under these nominee shareholder agreements, Prospect has the unilateral right to establish or effect a change of the nominee, at will, and without the consent of the nominee, on an unlimited basis and at nominal cost throughout the term of the Management Agreement. In addition to the Management Agreement with PMG, Prospect, through one of its management company subsidiaries, has a management agreement with each Affiliate. The term of the Management Agreements is generally 30 years. PMG is the sole shareholder of PHS, PPCM, Genesis, PNW, PSC, UMG, and PVMG.

The Company's Affiliates have entered into Management Agreements with PMS or PHCA, as applicable (each of which is a wholly-owned subsidiary of Prospect). Each Affiliate has agreed to pay a management fee to PMS or PHCA, as applicable. The fee is based in part on the costs to the management company and on a percentage of revenues the Affiliate receives (i) for the performance of medical services by the Affiliate's employees and independent contractor physicians and physician extenders, and (ii) for all other services performed by the Affiliates. The revenue from which this fee is determined includes medical capitation, all sums earned from participation in any risk pools and all fee-for-service revenue earned. The management fee also includes a fixed amount for marketing and public relations services. Except in the case of Nuestra and AMVI/Prospect, the Management Agreements had initial terms of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. Effective September 1, 2013, the Managements Agreements for the ProMed Entities were consolidated under one new Management Agreement with PHCA. Effective October, 1, 2013, the Management Agreements for the rest of the Affiliates, other than Nuestra and AMVI/Prospect, were consolidated under one new Management Agreement with PMS. Those two new Management Agreements with PHCA and PMS include initial five year terms and are renewable for successive five year periods thereafter. In the case of Nuestra, its Management Agreement had an initial 10 year term renewable for successive one year terms, subsequently amended in January 15, 2009 to an initial 20 year term renewable for two 10 year periods. In the case of AMVI/Prospect, the Management Agreement has a one year term with successive one year renewal terms. In return for payment of the management fee, Prospect (through PMS and PHCA) has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, Prospect has assumed the obligations for all facilities, medical and non-medical supplies, and employment of non-physician personnel of its affiliated medical clinics.

The management fee earned by Prospect fluctuates based on the profitability of each wholly-owned Affiliate. Prospect is allocated a 50% residual interest in any profits after the first 8% of the profits. The remaining balance is retained by the Affiliates.

The Management Agreements are not terminable by the Affiliates except in the case of gross negligence, fraud or other illegal acts of Prospect, or bankruptcy of the Company.

Further, Prospect's rights under the Management Agreements are unilaterally saleable or transferable. Based on the provisions of the Management Agreements and the assignable option agreement with PMG, Prospect has determined that it has a controlling financial interest in the Affiliates, with the exception of AMVI/Prospect. Consequently, under applicable accounting principles, Prospect consolidates the revenues and expenses of all the Affiliates except AMVI/Prospect from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of AMVI/Prospect, only that portion of the results which are contractually

identified as Prospect's are recognized in the consolidated financial statements, together with the management fee that the Company charges AMVI for managing AMVI's share of the joint venture operations.

Prospect has also entered into management agreements with unaffiliated third parties to manage services to their HMO enrollees. These management agreements do not have characteristics that give rise to the consolidation of the entities under current accounting literature.

The affiliated physician organizations provided medical services to a combined total of approximately 264,600 and 186,100 HMO enrollees as of September 30, 2014 and 2013, respectively. The enrollees include approximately 87,000 and 34,400 enrollees that the Company manages for the economic benefit of six independent third parties, and for which the Company earns management fee income as of September 30, 2014 and 2013, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2014 and 2013 was 2,785,000 and 2,193,000, respectively.

Effective October 1, 2012, the Company, through its newly created affiliate, New Genesis Medical Associates, Inc. ("NGMA"), dba Genesis Medical Clinic, acquired substantially all of the assets of a physician medical practice located in Orange County, California. NGMA is controlled through a nominee shareholder arrangement like the Stock Option structure utilized for PMG and discussed above.

On December 19, 2013, the Company, through its subsidiary NGMA, purchased stock of Chaparral Medical Group, Inc. ("CMG"), a California medical corporation. Consideration was composed of $1,100,000 in cash at the closing, $700,000 in future cash consideration to be used for the acquired company's general corporate purposes, and 3,750 shares of Ivy Holdings common stock issued at closing to the selling shareholders. After payment of the entire consideration, including the future cash consideration, Prospect will own 17.29% of the stock of CMG. Pursuant to the terms of the stock purchase agreement, Prospect will have the right and option to make additional stock investments at the same share valuations and prices and upon the same applicable terms and conditions as the initially acquired shares, to bring its aggregate ownership up to 50%. CMG is a 60 physician multi-specialty group serving communities primarily in the Los Angeles and San Bernardino counties. The Company accounts for NGMA's interest in CMG using the equity method as the Company has the ability to exercise significant influence over the operating and financial policies of CMG.

Corporate Segment

The Corporate segment reflects certain expenses incurred at the Parent Entity not specifically allocable to the Hospital Services or Medical Group segments. These include, but are not limited to: salaries, benefits and other compensation for corporate employees; financing expenses; insurance expenses; rent; legal fees; and accounting fees. The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of all controlled subsidiaries, which control is effectuated through ownership of voting common stock or by other means, but do not include the accounts of the parent companies, Ivy Holdings and Ivy Intermediate Holding Inc.

The Medical Group entities (subsidiaries) have been determined to be variable interest entities due to the existence of a call option under which the Company has the ability to require the holders of all of the voting common stock of the underlying subsidiaries to sell their shares at a fixed nominal price ($1,000) to another designated physician chosen by the Company. This call option agreement represents rights provided through a variable interest other than the equity interest itself that caps the returns that could be earned by the equity holders. In addition, the Company has a management agreement with the subsidiaries and the holders of the voting common stock of the subsidiaries which allows the Company to direct all of the activities of the subsidiaries, retain all of the economic benefits and assume all of the risks associated with ownership of the subsidiaries. In this manner, the Company has all of the economic benefits and risks associated with the subsidiaries but has disproportionately few voting rights (based on the terms of the equity). As the Company retains all of the economic benefits and assumes all of the risks associated with ownership of the subsidiaries, the Company is considered to be the primary beneficiary of the activities of the subsidiaries and therefore must consolidate the underlying subsidiaries.

Operating results for NGMA, Nix CGH, CMG, NSH and LACH Bellflower, and PCC are consolidated with the Company's financial statements from their acquisition dates or inception date in the case of LACH Bellflower (October 1, 2012, April 16, 2013, December 19, 2013, May 6, 2014, and June 20, 2014 respectively) (see Note 4). All significant intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Certain reclassifications were made to the 2013 consolidated financial statements in order to conform to the 2014 presentation.

Revenues

Revenues by reportable segment are comprised of the following amounts (in thousands):

For the Years Ended September 30,	2014 *(a)*	2013 *(b)*
Net Hospital Services		
Inpatient	$ 440,961	$ 403,183
Outpatient	96,802	63,382
Capitation	70,077	44,923
Other	11,116	6,718
Total Hospital Services revenues	618,956	518,206
Less: Provision for bad debts	(32,945)	(34,067)
Total net Hospital Services revenues less provision for bad debts	586,011	484,139
Medical Group		
Capitation	244,573	215,971
Management fees	6,586	2,352
Other	2,821	3,420
Total Medical Group revenues	253,980	221,743
Other revenues	14,525	7,700
Total net revenues	$ 854,516	$ 713,582

(a) CMG, NSH, and PCC revenues have been included in the accompanying consolidated financial statements for the period from acquisition, December 19, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014.

(b) NGMA and Nix CGH revenues have been included in the accompanying consolidated financial statements for the period from acquisition, October 1, 2012 and April 16, 2013, respectively, through September 30, 2013.

Hospital Services Segment

Net Patient Service Revenues

Operating revenue of the Hospital Services segment consists primarily of net patient service revenue. The Company reports net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others in the period in which services are rendered. The Company has agreements with third-party payers, including Medicare, Medicaid (Medi-Cal in California), managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

The following is a summary of sources of patient service revenues (net of contractual allowances and discounts) before provision for bad debts:

September 30,	2014	2013
Medicare	$ 224,984	$ 211,482
Medicaid	189,668	158,048
Managed Care	95,853	77,390
Self Pay/Other	27,258	19,645
Capitation	70,077	44,923
Other	11,116	6,718
Total	$ 618,956	$ 518,206

A summary of the payment arrangements with major third-party payers follows:

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons with end-stage renal disease and certain other beneficiary categories. Inpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Outpatient services are paid based on a blend of prospectively determined rates and cost-reimbursed methodologies. The Company is also reimbursed for various disproportionate share and Medicare bad debt components at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare fiscal intermediary. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

Cost report settlement estimates are recorded based upon as-filed cost reports and are usually not adjusted until a final Notice of Program Reimbursement ("NPR") is issued. The latest updated SSI ratios for 2012 were issued on June 12, 2014. To date, the Company has received final NPRs for Brotman Medical Center, Inc. through 2011 for cost report years prior to its merger into the Alta Hollywood Hospitals, Inc. subsidiary, SCH Hollywood through 2010, Alta Los Angeles Hospitals through 2010, and Nix Health through 2011. Additionally, the Company joined a second round of litigation relating to Medicare's recent settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, Alta Los Angeles Hospitals, SCH Culver City, and CharterCARE recognized a net benefit of $2,495,000, $1,230,000, and $1,672,000, respectively, during the year ended September 30, 2014 related to the Rural Floor litigation.

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the Medicaid program at prospectively determined rates for both inpatient and outpatient services. Medi-Cal is the version of the federal Medicaid program that is applicable to California residents. Inpatient services rendered to Medi-Cal fee-for-service program beneficiaries in California are in the process of a three-year transition to payment at prospectively determined rates based on diagnosis related groups from a contracted per diem rate. Outpatient services are paid based on prospectively determined rates per procedure provided. Inpatient and outpatient services rendered to Medi-Cal managed care beneficiaries in California are paid at either contracted rates or at the Medi-Cal fee-for-service rates. The SCHS and Alta Los Angeles Hospitals are eligible to participate in the State of California Medi-Cal Disproportionate Share ("DSH") programs, under which medical facilities that serve a disproportionate number of low-income patients receive additional reimbursements. Eligibility is determined annually based on prescribed guidelines. Prior to the merger of SCH Culver City with the SCH Hollywood and SCH Van Nuys Hospitals, SCH Culver City did not participate in the program. The Company accrues revenue based on the expected total annual DSH awards. Differences between the estimated and the actual awards are recorded in the period they become known. DSH amounts are subject to retrospective revision prior to finalization and such revisions could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional DSH revenues are recorded when the amounts are received. The Medi-Cal DSH receivable as of September 30, 2014 and 2013 totaled approximately $9,094,000 and $5,437,000, respectively, and were included in due from government program payers in the accompanying consolidated balance sheets. For fiscal years ended September 30, 2014 and 2013, total Medi-Cal DSH payments received by the SCHS and Alta Los Angeles Hospitals were approximately $16,325,000 and $11,618,000, respectively, and total Medi-Cal DSH revenues recorded were approximately $20,475,000 and $11,218,000, respectively. Additionally, pursuant to an audit of Medi-Cal cost reports and notification sent to the Company, the Company accrued a cost report liability payable to Medi-Cal of $1,803,000 and $1,316,000 as of September 30, 2014 and 2013, respectively.

During the fourth quarter of fiscal 2011, the Company's SCHS and Alta Los Angeles Hospitals received notification that the DSH amounts received related to the State fiscal year 2009-2010 were being re-examined and that the DSH amounts to be received for State fiscal years 2010-2011 would be significantly reduced. The notification was the result of legislation that extended payments under Senate Bill 90 ("SB 90"). During the year ended September 30, 2013, the Company recorded a reduction of $2,146,000 in Medi-Cal DSH revenue related to this matter. The matter had no impact on Medi-Cal DSH revenue during the year ended September 30, 2014.

Certain of the Company's California hospitals also participate in *the California Hospital Fee Program* (see Note 10).

In Texas, the Medicaid program reimburses under prospectively determined rates for both inpatient and outpatient services. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program. Nix Health has also been receiving payments from the Texas Health and Human Services Commission under the Section 1115 Waiver ("the waiver") that was recently granted to the state of Texas by CMS. Under the first year of the waiver ending September 30, 2012, a transition payment was paid to Nix Health based upon prior levels of payment under the "Upper Payment Limit" ("UPL") program, which the waiver replaced. Payments for years two through five under the waiver are based upon two pools. One pool is for payments for uncompensated care ("UCC") which includes the shortfall in Medicaid reimbursement as compared to cost and the cost of providing services to uninsured patients. The other pool is the Delivery System Reform Initiative Payments ("DSRIP"), where approved programs and services are undertaken to improve access and services provided. Programs are established by regions and approved by the Texas Health and Human Services Commission and CMS. These programs are assigned a value and milestones are established to measure success and the timing and level of payment from the DSRIP funds. Nix Health recorded revenue related to the UCC pool of $12,366,000 and $12,804,000 for the years ended September 30, 2014 and 2013, respectively. Revenue recorded related to the DSRIP pool was $9,801,000 and $7,078,000 for the years ended September 30, 2014 and 2013, respectively. At September 30, 2014 and 2013, amounts receivable under the Section 1115 Waiver totaled $23,145,000 and $14,781,000, respectively.

Nix Health also recorded $5,746,000 and $9,477,000 during the years ended September 30, 2014 and 2013, respectively, in costs for rural community provision of services. At September 30, 2014 and 2013, amounts payable related to such costs amounted to $0 and $4,754,000, respectively.

The CharterCARE hospitals are participants in the State of Rhode Island's DSH program, which was established in 1995 to assist hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the CharterCARE hospitals, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. Total DSH payments received and revenues recorded by the CharterCARE hospitals were $3,524,000 from June 20, 2014 (acquisition date) through September 30, 2014. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The CharterCARE hospitals recorded $4,036,000 of expense from June 20, 2014 through September 30, 2014 as a result of the license fee.

Managed Care: The Company has also entered into payment agreements with certain commercial insurance carriers, HMOs, and PPOs. The basis for payment under these agreements is in accordance with negotiated contracted rates or at the Company's standard charges for services provided. Some of these payments are capitated, meaning that the Company receives an agreed amount per patient for providing an agreed range of services.

Self-Pay: Self-pay patients represent those patients who do not have health insurance and are not covered by some other form of third party arrangement. Such patients are evaluated, at the time of services or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid, as well as the Company's local hospital's indigent and charity care policy.

See "Concentrations of Credit Risks" below for discussion of revenues received from the Medicare and Medicaid programs.

The Company accrued $895,000 of liabilities as of September 30, 2013 for ongoing Recovery Audit Contractor ("RAC") audits and other similar programs. Effective August 29, 2014, CMS provided a simplified process and timely partial payment to settle certain previously denied claims with dates of service prior to October 1, 2013 whereby such claims under appeal that had been retracted by CMS were settled with the provider receiving 68% of the face value. As a result, the Company recorded $3,887,000 in revenue during the year ended September 30, 2014 related to claims which were previously subject to ongoing RAC audits and other similar programs.

SCH Culver City Outlier Liability

Following the acquisition of a majority stake in SCH Culver City, effective April 14, 2009, the Company consolidated SCH Culver City's estimated liability to CMS arising out of outlier payments received for services provided by the hospital to Medicare eligible inpatients, primarily for the last four months of calendar year 2005 and all of calendar year 2006.

While SCH Culver City reports financial statements on a fiscal year ending September 30, Medicare cost reports are filed on a calendar year basis. Acute care hospitals receive Medicare reimbursement payments pursuant to a prospective payment methodology primarily based on the diagnosis of the patient, but are entitled to receive additional payments, referred to as "outliers" for patients whose treatment is very costly. When Brotman Medical Center, Inc. acquired the hospital in 2005, CMS provided a ratio of cost to charges (the "RCC") based on the statewide average. Payments received by SCH Culver City on this basis were an interim estimate, subject to final determination upon auditing of SCH Culver City's cost reports. SCH Culver City filed its Medicare cost reports, but determined that its outlier reimbursement for services provided in fiscal years 2005, 2006 and part of 2007 might be subject to adjustment based on certain outlier reconciliation rules. On October 12, 2012, SCH Culver City received from its Medicare fiscal intermediary a proposed outlier adjustment for Medicare fiscal year 2006 in the amount of $12,785,000. SCH Culver City had previously been notified of an adjustment of $2,149,000 for 2005. As of September 30, 2014 and 2013, the Company has accrued $13,834,000 of the estimated $14,934,000 liability to CMS included in the accompanying consolidated balance sheets. The difference between the $14,934,000 asserted by CMS and the $13,834,000 accrued by the Company relates to accrued interest of approximately $1,100,000. The Company does not agree, however, with the outlier reconciliation liability. Accordingly, in accordance with relevant literature related to accounting for contingencies, the Company has recorded to the lower end of the range. In March 2013, the Company received a notice of program reimbursement for the 2006 cost report year which approximated the October 2012 adjustment. The Medicare fiscal intermediary has placed the recoupment on hold while the Company is currently in discussions with CMS to resolve this issue. The ultimate resolution of this item is unknown at this stage. The Company has also filed an appeal of the outlier issue with the Provider Reimbursement Review Board for the 2006 cost reporting period since it received a notice of program reimbursement for the 2006 cost report. The ultimate resolution of this appeal is unknown at this stage.

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The following is a summary of due from and due to governmental payers at September 30 (in thousands):

September 30,	2014	2013
Due from government payers:		
Medi-Cal Disproportionate Share (DSH)	$ 9,094	$ 5,437
Medicare cost report settlements	10,279	7,191
Medicaid Section 1115 receivable	23,145	14,780
	$ 42,518	$ 27,408
Due to government payers:		
Outlier liability	$ 13,834	$ 13,834
Medicare cost report settlements	10,947	4,484
Medi-Cal cost report settlements	1,803	1,316
	$ 26,584	$ 19,634

The Company is not aware of any material claims, disputes, or unsettled matters with any payers that would affect revenues that have not been adequately provided for and disclosed in the accompanying consolidated financial statements.

Charity Care

The Company provides charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients with income levels between 300% and 350% of the Federal Poverty Level qualify to pay a discounted rate under the requirements of California State Assembly Bill 774 (AB 774) based on various government program reimbursement levels. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $2,029,000 and $1,003,000 for the years ended September 30, 2014 and 2013, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges of operating expenses, excluding depreciation, interest and management fees.

Provisions for Contractual Allowances and Bad Debts

Collection of receivables from third-party payers and patients is the Company's primary source of cash and is critical to its operating performance. The Company closely monitors its historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions for contractual allowances are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be materially different from the amounts management estimates and records. The Company's primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. Payments for services may also be denied due to issues over patient eligibility for medical coverage, the Company's ability to demonstrate medical necessity for services rendered and payer authorization of hospitalization.

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable increased from 27% at September 30, 2013 to 29% at September 30, 2014. The allowance for doubtful accounts was $49,727,000 and $28,050,000 for the years ended September 30, 2014 and 2013, respectively. The increase in the allowance for doubtful accounts as a percent of gross accounts receivable and in the allowance for doubtful accounts was due primarily to CharterCARE, which was acquired during the year ended September 30, 2014 and had an allowance for doubtful accounts of $16,839,000 at September 30, 2014.

Legislation

All of the Company's hospital facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements.

See Note 10 regarding the *Affordable Care Act*.

Other Revenues

Other revenues consist primarily of the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases, and totaled $14,525,000 and $7,700,000 for the years ended September 30, 2014 and 2013, respectively.

A summary of other revenues recorded during the years follows:

Rural Floor settlement: The Company entered into a settlement agreement with CMS and recognized $6,091,000 of revenue during the year ended September 30, 2014 related to the Rural Floor litigation.

Meaningful Use incentives: The American Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology or adopt or implement such technology. The Medicare incentive payments will be paid out to qualifying hospitals over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physicians must meet EHR "meaningful use" criteria that become more stringent over three stages.

Medicaid programs and payment schedules vary from state to state. The Medicaid programs require hospitals to register for the program prior to 2016, to engage in efforts to adopt, implement or upgrade certified EHR technology in order to qualify for the initial year of participation, and to demonstrate meaningful use of certified EHR technology in order to qualify for payment for up to three additional years.

For the years ended September 30, 2014 and 2013, the Company recorded revenues of $5,389,000 and $5,872,000, respectively, related to the Medicare and Medicaid programs in the consolidated statements of income. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rents is recorded on the straight-line method over the terms of the related lease agreements. During the years ended September 30, 2014 and 2013, the Company recorded rental revenues of $2,220,000 and $1,600,000, respectively.

Medical Group Segment

Medical Group Revenues

Operating revenue of the Medical Group segment consists primarily of payments for medical services procured by the Affiliates under capitated contracts with various managed care providers including HMOs. Capitation revenue under HMO contracts is prepaid monthly to the Affiliates based on the number of enrollees electing any one of the Affiliates as their health care provider. See "Concentrations of Credit Risks" below for revenues received from the five largest contracted HMOs.

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the Affiliates are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each individual enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments,

periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Company received and recorded as additional revenue, approximately $8,889,000 and $6,145,000, respectively, in positive capitation risk adjustments during the years ended September 30, 2014 and 2013, respectively.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the Affiliate can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2014 and 2013, Medical Group revenues included approximately $2,406,000 and $2,880,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2014 and 2013, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $5,547,000 and $6,365,000, respectively, based on the available information from the health plans.

The Company also receives incentives under "pay-for-performance" programs for quality medical care based on various criteria. These incentives, which are included in other revenues within Medical Group revenues, are generally recorded in the third and fourth quarters of the fiscal year when such amounts are known. Pay-for-performance revenues recorded during the years ended September 30, 2014 and 2013, were $1,886,000 and $2,375,000, respectively.

Management fee revenue is earned in the month the services are rendered. Management fee arrangements with unaffiliated entities provide for compensation ranging from 6.5% to 12.5% of revenues. Management fee revenues recorded during the years ended September 30, 2014 and 2013, were $6,586,000 and $2,352,000, respectively.

Medical Group Cost of Revenues

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. See Note 12 for changes in claims estimates during the years ended September 30, 2014 and 2013.

In addition to contractual reimbursements to providers, the Company also makes discretionary incentive payments to physicians, which are in large part based on the pay-for-performance and shared risk revenues and favorable senior capitation risk adjustment payments received by the Company. Since the Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known, the Company also finalizes

the discretionary physician bonuses in the same periods. During the years ended September 30, 2014 and 2013, the Company recorded discretionary physician incentives expense totaling approximately $5,067,000 and $3,993,000, respectively. As of September 30, 2014 and 2013, physician bonus accruals of approximately $4,339,000 and $2,623,000, respectively, were included in accounts payable and other accrued liabilities.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Property, Improvements and Equipment

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over five to ten years, buildings are depreciated over five to 28 years, equipment is depreciated over two to five years and furniture and fixtures are depreciated over two to seven years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset.

As more fully described in Note 10, the Company is required to comply with certain seismic standards as required by the state of California by January 1, 2020. The useful life of buildings subject to seismic retrofit requirements may be limited if the Company does not make the necessary upgrades by the required compliance date.

Goodwill and Other Intangible Assets

Goodwill totaled approximately $158,864,000 at both September 30, 2014 and 2013 and arose as a result of the ProMed, Alta, SCH Culver City, and Nix Health (including Nix CGH) acquisitions. Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. A two-step impairment test is used to identify potential goodwill impairment and to measure the amount of goodwill impairment loss to be recognized, if any. The Company has four reporting units with goodwill, consisting of the Alta Hospitals (which include SCH Hollywood, SCH Van Nuys, Los Angeles Community Hospital, and Norwalk Community Hospital), SCH Culver City, Nix Health, and ProMed (which includes other affiliated physician organizations).

The Company tests for goodwill impairment as of September 30 each year. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the

guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. The Company's impairment test related to goodwill at September 30, 2014 resulted in no impairment charge.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets totaled approximately $35,274,000 and $31,325,000, net of accumulated amortization at September 30, 2014 and 2013, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health, NGMA, and PCC acquisitions. Intangible assets include customer relationships, trade names, favorable leasehold, and physician guarantees. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the year ended September 30, 2014. During the year ended September 30, 2013, the Company changed the original names of the SCHS Hospitals and expects to transition into the new names over the next three years. As a result of the change, the Company recorded an impairment charge of $3,476,000 at September 30, 2013 related to the trade names (see Note 5).

Medical Malpractice Liability Insurance

The individual physicians who contract with the Affiliates carry their own medical malpractice insurance. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. During the year ended September 30, 2013, the SCHS Hospitals and Alta Los Angeles Hospitals were covered under one professional and general liability insurance policy, and Nix Health was covered under a separate policy. Effective October 1, 2013, the hospitals renewed the professional and general liability insurance under one consolidated policy with separate retentions for each entity that runs through September 30, 2014. LACH Bellflower, NSH, and CharterCARE were included under the consolidated policy from their respective dates of acquisition or inception (LACH Bellflower).

Accounting principles generally accepted in the United States of America require that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits)

based upon an actuarial valuation of the Company's historical claims experience of the Company's hospitals. At September 30, 2014 and 2013, the total gross claims liability was approximately $4,590,000 and $4,660,000 and insurance receivables were $618,000 and $1,487,000, respectively, and were estimated using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is continually monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of medical malpractice liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential medical malpractice claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law and that the employer's liability limits are $1,000,000 (excluding Nix Health and CharterCARE). Nix Health has opted out of the Texas Workers' Compensation system as a non-subscriber, and provides its employees with benefits for occupational injury or disease through an ERISA plan. Nix Health has an Employer's Excess Indemnity policy with a $25,000 deductible policy with limits of $10,000,000 per occurrence and $25,000,000 aggregate. CharterCARE was fully insured for workers' compensation claims with no deductible from June 20, 2014 through September 30, 2014. From October 1, 2012 to September 30, 2014, the Company's (excluding Nix Health and CharterCARE) workers' compensation coverage was written on a $250,000 incurred loss retro program without an aggregate loss limitation. At September 30, 2014 and 2013, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $7,210,000 and $4,409,000, respectively. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of the claims liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Asset Retirement Obligations

The Company recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Over time, the liability is accreted to its present value each period. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statement of operations. The Company has accrued $4,310,000 in other long-term liabilities related to asset retirement obligations for the CharterCARE hospitals as of September 30, 2014. There were no asset retirement obligations as of September 30, 2013.

Stock Options

On December 15, 2010, the Board of Directors (the "Ivy Board") of Ivy Holdings adopted the 2010 Stock Option Plan of Ivy Holdings Inc. (the "Ivy Plan") and, on December 16, 2010, the stockholders of Ivy Holdings adopted the Ivy Plan. The Ivy Plan provides that it shall be administered by the Compensation Committee of the Ivy Board. The Ivy Plan includes an Incentive Stock Option Agreement and a Non-Qualified Stock Option Agreement to be used in connection with the grant of options under the Ivy Plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, performance and CEO discretion.

Compensation costs for option awards are measured and recognized in the consolidated financial statements based on their grant date fair value, net of estimated forfeitures over the awards' service period. Options subject to variable accounting treatment are subject to revaluation at the end of each reporting period. The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of stock options granted. The fair value of restricted stock grants are determined on the date of grant, based on the number of shares granted and the quoted price or estimated fair market value of the Company's common stock. Equity-based compensation is classified within the same line items as cash compensation paid to employees.

Cash and Cash Equivalents

The Company considers all highly liquid debt instruments with initial maturities of 90 days or less to be cash equivalents. Cash and cash equivalents are primarily comprised of deposits with banks. The Company maintains its cash at banks with high credit-quality ratings.

Restricted Cash

At September 30, 2014 and 2013, $233,000 was held in a restricted account in connection with workers compensation arrangements, and $30,000 was restricted related to a capitation agreement. At September 30, 2014, a further $420,000 was restricted on behalf of Prospect CharterCARE SJHSRI, LLC for its School of Nursing as required by the U.S. Department of Education, $1,993,000 was restricted for research at CharterCARE hospitals, and $2,300,000 was restricted to meet certain regulatory requirements for PHP. At September 30, 2013, $300,000 was restricted in connection with a statutory deposit required by the Department of Managed Health Care for Knox-Keene licensing related to PHP.

Restricted Investments

The Company is required to keep restricted deposits by certain HMOs for the payment of claims. Such restricted deposits are classified as a current asset in the accompanying consolidated balance sheets, as they are restricted for payment of current liabilities. Investments also include certificates of deposit with maturity dates of more than 90 days when purchased.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or market. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method. On November 16, 2012, the Company issued $100 million of 8.375% senior secured notes (see note 8) and capitalized deferred financing costs of $3,948,000 associated with the

offering during the year ended September 30, 2013, which are reflected in deferred financing costs in the accompanying consolidated balance sheets.

Deferred financing costs at September 30, 2014 and 2013 are as follows (in thousands):

September 30,	2014			2013		
	Gross Book Value	Accumulated Amortization	Net Book Value	Gross Book Value	Accumulated Amortization	Net Book Value
Deferred financing costs	$14,398	$4,941	$9,457	$14,345	$2,720	$11,625

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the statements of operations. For the years ended September 30, 2014 and 2013, no interest and/or penalties related to incomes taxes were accrued and/or expensed.

An entity is required to evaluate its tax positions using a two-step process. First, the entity should evaluate the position for recognition. An entity should recognize the financial statement benefit of a tax position if it determines that it is more likely than not that the position will be sustained on examination. Next, the entity should measure the amount of benefit that should be recognized for those tax positions that meet the more-likely-than-not test.

Consolidated and separate income tax returns are filed with the U.S. Federal jurisdiction and in the State of California, Texas, and Rhode Island. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

The net deferred tax liabilities are primarily comprised of temporary differences between book and tax bases for intangible and capital assets acquired and net operating loss carryforwards.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash investments, patient and other accounts receivables, accrued salaries and benefits, accounts payable and accrued expenses, medical claims and related liabilities, amounts due to government agencies, notes receivable and payable, capital lease obligations, debt, and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value due to the relatively short period of time between the origination of the instruments and their expected realization.

Fair Value Measurement

Relevant accounting guidance establishes a framework for measuring fair value and clarifies that fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants.

The guidance requires disclosure about how fair value is determined for assets and liabilities and establishes a hierarchy for which these assets and liabilities must be grouped, based on significant levels of inputs as follows: Level 1 quoted prices in active markets for identical assets or liabilities; Level 2 quoted prices in active markets for similar assets and liabilities and inputs that are observable for the asset or liability; or Level 3 unobservable inputs for the asset or liability, such as discounted cash flow models or valuations. The determination of where assets and liabilities fall within this hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The Company's Level 1 assets include cash and cash equivalents and investments (certificates of deposit and money market mutual funds). The inputs for fair value of goodwill and intangible assets (including long lived assets and intangible assets subject to amortization) would be based on Level 3 inputs as data used for such fair value calculations would be based on discounted cash flows that are not observable from the market, directly or indirectly.

Financial Items Measured at Fair Value on a Recurring Basis

The following table sets forth the Company's financial assets and liabilities measured at fair value on a recurring basis and where they are classified within the hierarchy (in thousands):

	Total	Level 1	Level 2	Level 3
As of September 30, 2014				
Certificates of deposit and money market mutual funds	$ 642	$ 642	$ -	$ -
As of September 30, 2013				
Certificates of deposit and money market mutual funds	$ 637	$ 637	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

Nonfinancial assets such as goodwill and identifiable intangible assets are measured at fair value when there is an indicator of impairment and recorded at fair value only when impairment is recognized. The Company performs an annual impairment test on the goodwill, and performs an impairment test on the intangibles when there are indications of impairment.

The following table presents the fair value of intangible assets subject to amortization measured at fair value during the year ended September 30, 2013 and included in the Company's consolidated balance sheet as of September 30, 2013 (in thousands):

	Total	Fair Value Measurement Using			Total impairment
		Level 1	Level 2	Level 3	
Trade names	$ 1,940	$ -	$ -	$ 1,940	$ (3,476)

During the year ended September 30, 2013, the Company recorded $3,476,000 of impairment relating to intangible assets subject to amortization, which is reflected in the accompanying consolidated statements of income. No impairment was recorded during the year ended September 30, 2014.

The Company uses the discounted cash flow approach to estimate the fair value of the Company's trade names. The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment as of September 30, 2013:

Fair value of trade names	Valuation Technique	Unobservable Input	Rates
$ 1,940	Discounted cash flow	Weighted average cost of capital	13.0% - 13.5%
		Revenue growth rate	2% - 3%
		Reduction of revenue attributable to trade names	(30%) - (70%)
		Royalty rate	1.0%

Significant increases or decreases in the Company's weighted average cost of capital may result in a significantly lower or higher fair value measurement, respectively. Significant increases or decreases in the revenue growth rate and royalty rates in isolation may result in a significantly higher or lower fair value measurement, respectively. The fair values of the Company's current financial liabilities approximate their reported carrying amounts. The carrying values and the fair values of non-current financial liabilities that qualify as financial instruments under the guidance are as follows (in thousands).

	2014		2013	
September 30,	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	$ 421,888	$ 457,620	$ 421,067	$ 449,339

The fair value of the Company's long-term debt was determined based on market prices.

Concentrations of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, at times, balances may exceed federally insured limits of $250,000 per depositor of each financial institution. The Company has not experienced any losses to date related to these balances.

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare, Medicaid (Medi-Cal in California), patients, health plans including shared-risk arrangements, and notes receivable.

The Company invests excess cash in liquid securities at institutions with strong credit ratings, following established guidelines relative to diversification and maturities to maintain safety and liquidity. These guidelines are periodically reviewed and modified to take into consideration trends in yields and interest rates and principal risk. Management attempts to schedule the maturities of the Company's investments to coincide with the Company's expected cash requirements. Credit risk with respect to receivables is limited since amounts are generally due from large HMOs within the Medical Group Management segment and from the Medicare and Medicaid (Medi-Cal in California) programs within the Hospital Services segment. Notes receivable are fully secured by collateral of equal or greater value. Management reviews the financial condition of these institutions on a periodic basis and does not believe the concentration of cash or receivables results in a high level of risk.

For the years ended September 30, 2014 and 2013, the Hospital Services segment received a total of 67% and 71%, respectively, of its net patient revenues from Medicare and Medicaid programs, and the Medical Group segment received a total of 63% and 69%, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2014	% of Total Revenue	2013	% of Total Revenue
Hospital Services:				
Government Payers:				
Medicare	$ 224,984	36%	$ 211,482	41%
Medicaid	189,668	31%	158,048	30%
Total	$ 414,652	67%	$ 369,530	71%
Medical Group:				
HMO A	$ 33,784	14%	$ 36,194	17%
HMO B	31,632	13%	28,346	13%
HMO C	31,481	13%	31,735	15%
HMO D	31,283	13%	28,754	13%
HMO E	25,133	10%	23,159	11%
Totals	$ 153,313	63%	$ 148,188	69%

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities at the dates, and for the periods, that the consolidated financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include third party settlements, settlements under risk sharing programs, allowances for contractual discounts and doubtful accounts, accruals for medical claims, impairment of goodwill, long-lived assets and intangible assets, share-based payments, professional and general

liability claims and workers' compensation claims, reserves for outcome of legislation and valuation allowances against deferred tax assets.

New Accounting Pronouncements

In June 2011, the FASB issued an accounting standards update that specifies that the liability for the annual fee imposed on certain health insurers under the recently enacted Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. This update is effective for calendar years beginning after December 31, 2013, when the fee initially becomes effective. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In July 2013, the FASB issued an accounting standards update that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In May 2014, the FASB issued ASU No. 2014-09, Revenue from Contracts with Customers (ASU 2014-09). The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2017, including interim periods therein. Three basic transition methods are available – full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. October 1, 2018) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is prohibited. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

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3. Property, Improvements and Equipment

Property, improvements and equipment, consisted of the following (in thousands):

September 30,	2014	2013
Property, improvements and equipment:		
Land and land improvements	$ 53,381	$ 34,985
Buildings and improvements	119,163	59,270
Leasehold improvements	22,967	4,007
Equipment	87,249	64,842
Furniture and fixtures	7,187	5,759
	289,947	168,863
Less: accumulated depreciation	(60,473)	(42,331)
Property, improvements and equipment, net	$ 229,474	$ 126,532

Effective May 6, 2014, Prospect acquired the property, improvements, and equipment of Bellflower Medical Center, located in Bellflower, California, for cash consideration of $20 million. The assets, including land and building, were named Los Angeles Community Hospital at Bellflower. Bellflower Medical Center was closed in 2013 by its previous owner and was not operational since that time. The Company accounted for this transaction as an acquisition of assets. The primary factors influencing the determination that the acquisition should be accounted for in this manner included the complete closure of the hospital, the fact that there were no inputs and/or processes acquired, the requirement for significant additional capital expenditures and development efforts to reopen the hospital, and the lack of acquired workforce. Accordingly, the Company determined that this transaction lacked the key characteristics for business combination accounting. In addition to the $20 million purchase price, Prospect capitalized $546,000 of transaction costs directly related to the purchase of these assets. The purchase price and transaction costs were allocated to the assets acquired based on the relative fair value of the acquired assets.

On July 18, 2013, Nix Health entered into a lease agreement to rent land and building located in the city of San Antonio, Texas, which was used for a 73-bed behavioral health center which was opened during the year ended September 30, 2014. The Company determined that the lease qualified as a capital lease and recorded fixed assets of $5,675,000 and a capital lease liability of $6,902,000 as of September 30, 2013. The difference of $1,227,000 relates to a tenant improvement allowance from the landlord, which was used for construction costs during the year ended September 30, 2014.

During the years ended September 30, 2014 and 2013, the Company made investments of approximately $7,633,000 and $6,200,000, respectively, in equipment related to implementation of EHR technology and new hospital systems at the Company's hospitals.

At September 30, 2014 and 2013, the Company had assets under capitalized leases of approximately $19,294,000 and $17,288,000, respectively, and related accumulated depreciation of $11,465,000 and $7,350,000, respectively.

Depreciation expense was approximately $18,386,000 and $12,443,000 for the years ended September 30, 2014 and 2013, respectively.

4. Acquisitions

Newport Specialty Hospital

Effective May 6, 2014, Prospect acquired substantially all of the assets of Newport Specialty Hospital ("NSH") for cash consideration of $15 million. NSH, located in Tustin, California was substantially closed prior to acquisition, operating only its pediatric subacute unit as of the acquisition date.

The acquisition of NSH was accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. This transaction resulted in a bargain gain of approximately $523,000, which is included in other income in the accompanying consolidated statements of income. The Company incurred $556,000 and $37,000 of transaction costs during the years ended September 30, 2014 and 2013, respectively, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the NSH acquisition, as of May 6, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)
Property, improvements and equipment	$ 15,523
Bargain purchase gain	(523)
Net cash consideration	$ 15,000

CharterCARE

Effective June 20, 2014, Prospect, through its newly formed subsidiary, PCC, acquired substantially all of the assets of CharterCARE Health Partners and its subsidiaries in exchange for a 15% interest in PCC, $43.3 million in cash and a commitment to invest at least $50 million in PCC and its subsidiaries for strategic business development and capital improvements over the next four years. As a result of the acquisition, PCC is owned 85% by Prospect and 15% by CharterCARE Health Partners (which was subsequently renamed CharterCARE Community Board).

PCC, through its subsidiaries, operates Roger Williams Medical Center, St. Joseph Health Services of Rhode Island, and Elmhurst Extended Care Facilities, Inc., which operate hospitals, medical centers and assisted living facilities located in Rhode Island with approximately 785 licensed beds.

The acquisition was accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. This transaction resulted in a bargain gain of approximately $4,294,000, which is included in other income in the accompanying consolidated statements of income. Subsequent to September 30, 2014, the Company received $2,125,000 for a working capital adjustment, which resulted in a reduction in total consideration and an increase in the bargain gain recognized during the year ended September 30, 2014.

The following table summarizes the assets acquired and liabilities assumed in connection with the PCC acquisition, as of June 20, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)
Restricted cash	$ 1,739
Patient accounts receivable and other receivables	34,264
Prepaid expenses and other current assets	8,777
Property, improvements and equipment	53,642
Intangible assets	8,590
Other long-term assets	4,698
Accounts payable and other liabilities	(44,656)
Capital leases	(1,315)
Long-term debt	(25)
Other long-term liabilities	(4,645)
Net assets acquired	61,069
Less: amount attributable to non-controlling interest	(9,160)
Net assets acquired by Prospect	51,909
Total purchase consideration	47,615
Bargain purchase gain	$ 4,294

The total purchase consideration of $47,615,000 includes net cash consideration of $41,175,000 after the working capital adjustment plus a long-term liability of $6,440,000, which represents the discounted fair value of the non-controlling interest's 15% interest in the $50 million future commitment of the Company to PCC as part of the Purchase Agreement. The Company's long-term liability increased from $6,440,000 as of June 20, 2014 to $6,506,000 as of September 30, 2014 due to accretion of the liability.

The Company incurred $2,145,000 and $976,000 of transaction costs during the years ended September 30, 2014 and 2013, respectively, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

New Genesis Medical Associates

On October 1, 2012, the Company, through its newly created affiliate, New Genesis Medical Associates, Inc. dba Genesis Medical Clinic, a California professional medical corporation, acquired substantially all of the assets of a physician medical practice located in Orange County, California. The consideration for the NGMA acquisition consisted of approximately $400,000 in cash. The acquisition of NGMA is accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values.

The following table summarizes the assets acquired in connection with the NGMA acquisition, as of October 1, 2012 (in thousands):

	Purchase Price Allocation
Property, improvements and equipment	$ 50
Intangible assets	350
Net cash consideration	$ 400

Nix Community General Hospital

On April 16, 2013, the Company acquired substantially all of the assets and assumed certain liabilities of Community General Hospital of Dilley, Texas Inc. dba Community General Hospital, a hospital with 18 licensed beds, which offers Dilley, Texas and the surrounding communities an array of medical services including primary care. Upon close of the transaction, the hospital was renamed to Nix Community General Hospital. The consideration for the Community General Hospital acquisition included approximately $2,705,000 in cash, contingent cash consideration of $250,000 and assumption of approximately $795,000 in liabilities, for total consideration of approximately $3,750,000. The acquisition of Community General Hospital is accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. The Company incurred $255,000 of transaction costs during the years ended September 30, 2013, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the Community General Hospital acquisition, as of April 16, 2013 (in thousands):

	Purchase Price Allocation
Current assets	$ 7
Property, improvements and equipment	1,267
Goodwill	2,476
Contingent cash consideration	(250)
Accounts payable and other liabilities	(795)
Net cash consideration	$ 2,705

As an asset purchase, the goodwill and the intangible assets acquired in the PCC, NGMA and Nix CGH acquisitions are deductible for tax purposes.

5. Goodwill and Intangible Assets

As of September 30, 2014 and 2013, goodwill and intangible assets relate to the ProMed, Alta, SCH Culver City, Nix Health, NGMA, Nix CGH, and PCC acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units.

For the Medical Group segment, the Company has determined that PHCA and the ProMed Entities (collectively referred to as "ProMed"), as well as PMS and the other affiliated physician organizations as a group (collectively referred to as "Prospect IPAs") each constitutes a separate reporting unit. NGMA is consolidated within the Prospect reporting unit.

For the Hospital Services segment, the reporting unit for the annual goodwill impairment analysis is determined to be at the business unit level. A separate analysis was prepared for Alta Hospitals, SCH Culver City, and Nix Health. Nix CGH is consolidated within the Nix Health business unit.

During the year ended September 30, 2013, the Company recorded additional goodwill of $2,476,000 related to the Nix CGH acquisition. In addition, the Company recorded a working capital adjustment of $157,000 against the goodwill balance related to the Nix Health acquisition.

The carrying value of goodwill for Alta Hospitals, SCH Culver City, Nix Health (including Nix CGH), and ProMed at September 30, 2014 and 2013 was $106,539,000, $24,373,000, $5,613,000, and $22,339,000, respectively.

The following is a rollforward of goodwill from October 1, 2012 to September 30, 2014 (in thousands):

	Amount
Balance, October 1, 2012	$ 156,545
Acquisition of Nix CGH (see Note 4)	2,476
Working capital adjustments - Nix Health (see Note 4)	(157)
Balance, September 30, 2013	158,864
Balance, September 30, 2014	$ 158,864

Identifiable intangible assets are comprised of the following (in thousands):

	September 30, 2014						
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,596	-	-	-	1,596
Customer relationships	-	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,356	8,590	350	34,650	59,576
Accumulated amortization	(3,670)	(440)	(2,171)	(482)	(100)	(17,439)	(24,302)
Intangible assets, net	$ 6,640	$ 880	$ 2,185	$ 8,108	$ 250	$ 17,211	$ 35,274

	September 30, 2013					
	Alta	SCH Culver City	Nix Health	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	-	9,450	23,820
Favorable leasehold	-	-	20	-	-	20
Physician guarantees	-	-	1,537	-	-	1,537
Customer relationships	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,297	350	34,650	50,927
Accumulated amortization	(2,978)	-	(1,513)	(50)	(15,061)	(19,602)
Intangible assets, net	$ 7,332	$ 1,320	$ 2,784	300	$ 19,589	$ 31,325

During the year ended September 30, 2013, the Company changed the names of the hospitals owned by SCHS to SCH Hollywood, SCH Van Nuys, and SCH Culver City. The fair value of the original trade names at September 30, 2013 was estimated using the relief-from-royalty method and their remaining useful lives were reduced to three years based on the Company's planned use of the trade names. As a result of the valuation, the trade names were valued at $1,940,000 and the Company recorded an impairment charge of $3,476,000 for the year ended September 30, 2013, which is presented as part of operating expenses in the accompanying consolidated statements of income. The Company adjusted the cost basis of the trade names to the new fair value, which resulted in writing off $5,510,000 of gross intangibles and accumulated amortization of $2,034,000. There were no impairments recorded for the year ended September 30, 2014.

During the year ended September 30, 2014 and 2013, intangibles related to physician guarantees, covenants not-to-compete and provider networks of $487,000 and $3,300,000, respectively, were fully amortized and removed from intangible assets.

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2014 and 2013 was approximately $5,194,000 and $4,371,000, respectively.

Estimated amortization expense for each future fiscal year is as follows (in thousands):

Years ended September 30,	
2015	$ 6,345
2016	6,146
2017	4,869
2018	4,632
2019	4,149
Thereafter	9,133
Total	$ 35,274

The following table shows the estimated useful lives for each of the intangible assets:

	Estimated useful lives
HMO membership	14 years
Trade names	3 - 20 years
Favorable leasehold	6 years
Physician guarantees	2 to 3 years
Customer relationships	7 years

The weighted-average remaining useful life for the intangible assets was 7.13 years as of September 30, 2014.

6. Related Party Transactions

Jeereddi Prasad, M.D., a shareholder of Ivy Holdings, a director of Ivy Holdings and the Company, and an officer of the ProMed Entities, has ownership interests in physician medical groups that provide medical services to ProMed members, including CMG. For the years ended September 30, 2014 and 2013, the ProMed Entities paid these groups approximately $12,677,000 and $16,742,000, respectively.

Pursuant to a Management Services Agreement, dated December 15, 2010 and amended on May 3, 2012 (the "LGP Management Agreement"), between the Company and Leonard Green & Partners, L.P. ("LGP"), a private equity fund with affiliated funds that collectively constitute the majority shareholder of Ivy Holdings, LGP provides to the Company, (a) certain investment banking services, (b) management, consulting and financial planning services and (c) financial advisory and investment banking services in connection with major financial transactions from time to time. In consideration for the services provided by LGP under the LGP Management Agreement, the Company pays LGP an annual fee of $1,000,000, payable in monthly installments, and reimburses LGP for its related expenses up to $50,000 annually. If approved by the unanimous consent of the Board of Directors of the Company, additional customary fees may be due to LGP pursuant to the terms of the LGP Management Agreement for services rendered in connection with major transactions from time to time.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. During the years ended September 30, 2014 and 2013, the Company made payments under this arrangement of $5,703,000 and $17,477,000, respectively.

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7. Income Taxes

The components of the income tax provision are as follows (in thousands):

For the years ended September 30,	2014	2013
Current:		
Federal	$ 14,430	$ 8,000
State	4,242	2,184
	18,672	10,184
Deferred:		
Federal	(4,529)	(318)
State	(3,582)	(56)
	(8,111)	(374)
Total:		
Federal	9,901	7,682
State	660	2,128
	$ 10,561	$ 9,810

Temporary differences and carry forward items that result in deferred income tax balances as of September 30 are as follows (in thousands):

September 30,	2014	2013
Deferred tax assets:		
State tax benefit	$ 2,593	$ 2,103
Allowances for bad debts	5,119	4,304
Vacation accrual and other	5,440	4,434
Workers compensation	2,656	1,889
Accrued bonuses	3,898	4,847
Malpractice reserves	1,952	1,204
Deferred rent	107	105
Enterprise zone tax credit	2,433	-
Other	359	379
Net operating losses	8,789	8,798
Capital loss carryforward	2,274	2,255
Deferred tax assets	35,620	30,318
Valuation allowance	(10,737)	(10,742)
Net deferred tax assets	24,883	19,576
Deferred tax liabilities:		
Intangible assets	(7,247)	(8,211)
Fixed assets	(17,664)	(21,038)
Deferred compensation	(112)	-
Partnership outside basis difference	(1,982)	-
Prepaid expenses	(21)	(581)
Deferred tax liabilities	(27,026)	(29,830)
Net deferred tax liabilities	$ (2,143)	$ (10,254)

Deferred tax assets and liabilities reflect the effect of temporary differences between the assets and liabilities recognized for financial reporting purposes and the amounts recognized for income tax purposes.

For the year ended September 30, 2013, the Company released $8,000,000 of deferred tax valuation allowance in connection with net operating losses that became available for use due to the Brotman Medical Center and Alta Hollywood Hospitals merger. The Company maintains approximately $10,737,000 and $10,742,000 as of September 30, 2014 and 2013, respectively, of valuation allowance against its deferred tax assets for capital loss and certain net operation loss carry forwards subject to limitations under tax law. At September 30, 2014, the Company had federal and state net operating loss carryovers of approximately $17,935,000 and $34,039,000 which, if not utilized, will expire beginning 2034 and 2024, respectively. A substantial portion of these net operating loss carry forwards are subject to limitations under Internal Revenue Code Section 382, and their use may be severely limited in the future.

During the year ended September 30, 2013, the Internal Revenue Service ("IRS") concluded its audit of SCH Culver City for the years ended September 30, 2008 through 2010 and its audit of PMG for the year ended September 30, 2010. During the year ended September 30, 2014, the IRS completed its audit of PMH for the year ended September 30, 2010 and the period from October 1, 2010 to December 15, 2010 with no adjustments. The Company's tax years 2010 and after are generally open for federal and state tax examination. At September 30, 2013, the Company has approximately $970,000 of unrealized excess tax benefits related to employee stock options. This amount is not included in the table of deferred tax assets above and the benefit will be recorded as an increase to additional paid in capital if and when realized.

The Company does not have any material unrecognized benefit as of September 30, 2014 and does not anticipate that any material change will occur within the next 12 months.

The differences between the income tax provision at the federal statutory rate and that reflected in the accompanying consolidated statements of operations are summarized as follows:

For the years ended September 30,	2014	2013
Tax provision at statutory rate	35%	35%
State taxes, net of federal benefit	6%	6%
Permanent and other items	0%	3%
Enterprize zone tax credits	(7)%	0%
Change in valuation allowances	0%	(19)%
Other	2%	(2)%
	36%	**23%**

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8. Long-Term Debt

Long-term debt consists of the following (in thousands):

September 30,	2014	2013
Prospect's debt:		
Senior secured notes		
2019 Notes	$ 325,000	$ 325,000
Less: discount, net	(6,339)	(7,641)
	318,661	317,359
Additional 2019 Notes	100,000	100,000
Plus: premium, net	1,419	1,729
	101,419	101,729
Other	-	21
	420,080	419,109
Nix Health's debt:		
Mortgage debt	1,801	1,919
Note payable	-	39
	1,801	1,958
Other debt:	7	-
Total Debt:	421,888	421,067
Less: current maturities	(133)	(178)
Long-term debt, net of current maturities	$ 421,755	$ 420,889

Prospect's Debt:

Senior Secured Notes

On May 3, 2012, the Company closed the offering of $325 million in 8.375% senior secured notes due May 1, 2019 ("PMH 2019 Notes"). Interest is payable semi-annually in arrears on May 1 and November 1, commencing on November 1, 2012. The offering was executed in accordance with Rule 144A and Regulation S under the Securities Act of 1933. The terms of the PMH 2019 Notes are governed by an indenture among the Company, certain of its subsidiaries and affiliates (as "Guarantors"), and U.S. Bank National Association (as trustee) (the "Indenture"). The Indenture contains certain covenants that, among other things, limit the Company's ability, and the ability of its restricted subsidiaries (as such term is defined in the Indenture) to: retire and pay dividends or distributions on capital stock or equity interests, prepay subordinated indebtedness or make other restricted payments; incur additional debt; make investments; create liens on assets; enter into transactions with affiliates; engage in other businesses; sell or issue capital stock of restricted subsidiaries; merge or consolidate with another company; transfer and sell assets; create dividend and other payment restrictions affecting subsidiaries; and designate unrestricted subsidiaries. The Credit Agreement (defined below), executed in connection

with the PMH Senior Secured Credit Facility (discussed below), contains a number of customary covenants as well as covenants requiring the Company to maintain a maximum consolidated secured leverage ratio and limiting the amount of capital expenditures.

Concurrent with the issuance of the PMH 2019 Notes, the Company entered into a five year $50 million revolving senior secured credit facility (the "PMH Senior Secured Credit Facility") which replaced the existing senior secured credit facility. The PMH Senior Secured Credit Facility provides, among other things, for borrowings up to the amount of the facility with sublimits of up to (i) $20 million to be available for the issuance of letters of credit and (ii) $10 million to be available for swingline loans. The commitment under the facility may be increased by up to $10 million upon the Company's request at the discretion of the lenders and subject to certain customary requirements. The interest rate per annum applicable to loans under the PMH Senior Secured Credit Facility will be, at the Company's option, either a rate per annum equal to (i) LIBOR plus 3.50% or (ii) an alternate base rate, which will be the higher of the administrative agent's prime rate, the federal funds rate plus 0.50%, and the 1-month LIBOR rate plus 1.00%, plus in each case, 2.50%. In August 2013, the PMH Senior Secured Credit Facility limit was increased to $60 million. As of September 30, 2014, the Company had $20 million outstanding debt related to the PMH Senior Secured Credit Facility.

The PMH 2019 Notes and the PMH Senior Secured Credit Facility are jointly and severally guaranteed on a senior secured basis by all of the Company's subsidiaries (as such term is defined in the Indenture) other than AMVI/Prospect Medical Group, Nuestra and certain immaterial subsidiaries. The PMH 2019 Notes are secured pari passu with the PMH Senior Secured Credit Facility by first-priority Liens and security interests on substantially all of the tangible and intangible assets of the Guarantors, including, but not limited to, the accounts receivable, inventories, other personal property, real property, fixtures and equipment, in each case now owned or hereafter acquired by the Company and the Subsidiary Guarantors, with certain exceptions. The PMH 2019 Notes are effectively senior to all of the Guarantors' existing and future Indebtedness.

The terms of the PMH Senior Secured Credit Facility are governed by the Credit Agreement, dated as of May 3, 2012, (as amended in connection with the Company's November 2012 offering of additional PMH 2019 Notes - see below) among the Company, Morgan Stanley Senior Funding, Inc. (as administrative agent), Royal Bank of Canada and Credit Suisse AG, Cayman Islands Branch (as co-syndication agents) and the lenders party thereto (the "Credit Agreement").

The Company, at its option, may redeem all or part of the notes at a redemption price equal to 106.281%, 104.188%, 102.094% and 100.0% on or after May 1, 2015, 2016, 2017 and 2018, respectively. Prior to May 1, 2015, the Company, at its option, may (i) redeem up to 35% of the original principal amount of the notes with the proceeds of certain equity offerings at a redemption price of 108.375% (ii) redeem up to 10% of the original principal amount of the PMH 2019 Notes during each 12-month period, commencing on May 1 in each of 2012, 2013 and 2014, at a redemption price of 103.0% of the principal amount thereof (this redemption option was terminated in connection with the Company's November 2012 offering of additional PMH 2019 Notes) or (iii) redeem the PMH 2019 Notes, in whole, but not in part, at a redemption price of 100.0% of the aggregate principal plus a make-whole premium. There are no required principal payments on the PMH 2019 Notes until maturity.

On November 16, 2012, the Company closed the offering of $100 million in aggregate principal amount of 8.375% senior secured notes due 2019 (the "Additional 2019 Notes") at a price equal to 102% of the principal amount of the Additional 2019 Notes. The Additional 2019 Notes were issued in a private placement to qualified institutional buyers and form a part of the same series as the PMH 2019 Notes issued on May 3, 2012.

The Additional 2019 Notes were issued under the Indenture, dated May 3, 2012 and described above, as supplemented by two supplemental indentures entered into in connection with the issuance of the Additional 2019 Notes (the "Supplemental Indentures"). The Additional 2019 Notes are treated as a single series with the previously issued PMH 2019 Notes for all purposes under the Indenture, including, without limitation, restrictive covenants, waivers, amendments, redemptions and offers to purchase. Prior to closing the issuance of the Additional 2019 Notes, the Company was required to obtain the consent of the majority in interest of its PMH 2019 Notes issued on May 3, 2012 to certain amendments to the Indenture contained in the first Supplemental Indenture. The Company obtained such consent from the holders of approximately $324 million in aggregate principal amount of outstanding PMH 2019 Notes and paid an aggregate consent fee of approximately $8.9 million. The Company determined that the transaction represents a debt modification under the applicable accounting guidance and capitalized the consent fee and recorded it as a debt discount during the year ended September 30, 2013, which is being amortized over the term of the Additional 2019 Notes using the effective interest method. As of September 30, 2013, the aggregate outstanding principal balance of the PMH 2019 Notes was $425,000,000, net of unamortized original issue discount of $7,641,000 and plus unamortized original issue premium of $1,729,000.

The proceeds from the offering, together with approximately $10.9 million of the Company's available cash, were utilized to pay a dividend to the stockholders of the Company's indirect parent, Ivy Holdings, in an aggregate amount equal to $100 million, to pay the aforementioned $8.9 million consent fee and to pay approximately $2.5 million for other fees and expenses related to the offering.

In connection with the issuance of the Additional 2019 Notes, the Company entered into an amendment of its Credit Agreement governing the PMH Senior Secured Credit Facility that waived and amended certain provisions of the Credit Agreement, including certain restrictive covenants.

As of September 30, 2014 and 2013, the Company was in compliance with the financial covenants of the Indenture and Credit Agreement.

Demand Notes

During the year ended September 30, 2012, the Company obtained a commitment from a bank for a $9.3 million equipment leasing facility to finance various equipment at the Company's hospital facilities. During January 2014, the commitment was increased to $22.3 million. As of September 30, 2014 and 2013, $10.7 million and $8.4 million, respectively, were drawn under the facility and are classified as capital lease arrangements. Draws represent demand notes until conversion to capital leases, and interest accrues on such draws at the bank prime rate plus 1.5% with a floor of 4.5% and payable monthly.

Nix Health's Debt:

Mortgage Debt

In connection with the Nix Health acquisition, Nix SPE, LLC ("Nix SPE") executed a Loan Assumption Agreement, effective as of February 29, 2012, pursuant to which Nix SPE assumed the obligations of the sellers of Nix Health under a mortgage loan facility provided by The Ohio National Life Insurance Company on December 27, 1999. Nix SPE assumed the obligation to pay the outstanding principal amount of the mortgage loan and interest accruing thereafter. The outstanding balance of the mortgage loan as of September 30, 2014 and 2013 was $1,801,000 and $1,919,000, respectively.

Prospect Hospital Holdings, LLC, the parent company of Nix SPE, has provided a guaranty of the obligations of Nix SPE under the loan. The obligations under the loan facility are secured by a deed of trust on a neighborhood medical center known as Nix Alamo Heights. The loan is subject to a 7.0% interest rate and requires monthly installment payments of $20,674, with a balloon payment on the maturity date of November 1, 2019. Prepayment is subject to a fee and the loan contains customary covenants.

Note Payable

Nix Health entered into a note payable due in March of 2014. Interest accrued on this note at 8.96% and was payable monthly. The outstanding balance of this note as of September 30, 2013 was $39,000, and the note payable was repaid during the year ended September 30, 2014.

Scheduled payments under the Company's current and long-term debt as of September 30, 2014 are as follows (in thousands):

Years ending September 30,	
2015	$ 133
2016	135
2017	145
2018	155
2019	420,247
Thereafter	1,073
	$ 421,888

9. Stockholder's Deficit

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that authorized the issuance of options exercisable for up to 155,110 shares of the common stock of Ivy Holdings to employees, certain consultants and independent members of the boards of directors, of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). During the years ended September 30, 2014 and 2013, the Compensation Committee of the Board of Directors of Ivy Holdings ("Compensation Committee") granted 4,113 and 18,462 options to certain members of the Company's management and employees. These options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, Company and Business Unit performance based on EBITDA targets and CEO and Compensation Committee discretion. Since the Ivy Holdings stock options were granted to Company employees for their services related to the Company, the related compensation cost has been recorded in the Company's consolidated financial statements.

Under the terms of the Ivy Plan, the exercise price of an incentive stock option ("ISO") may not be less than 100% of the fair market value of the Company's common stock on the date of grant and, if granted to a shareholder owning more than 10% of the Company's common stock, then not less than 110%. Stock options granted under the Ivy Plan have a maximum term of 10 years from the grant date, and are exercisable at such time and upon such terms and conditions as determined by the Compensation Committee. Stock options granted to employees generally vest over four years, subject to continued service, performance, and other criteria. In the case of an ISO, the amount of the aggregate fair market

value of common stock with respect to which the ISO grant is exercisable, for the first time by an employee during any calendar year, may not exceed $100,000.

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2014 and 2013 and activity during the years then ended:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of September 30, 2012	112,583	$ 100.00	$ 20.00	104.2
Granted	18,462	120.00	–	–
Exercised	(3,513)	30.00	–	–
Canceled/Forfeited	(9,255)	61.68	–	–
Outstanding as of September 30, 2013 *(1)*	118,277	43.44	76.56	95.8
Granted	4,113	120.00	–	–
Exercised	–	–	–	–
Canceled/Forfeited	(5,957)	58.71	–	–
Outstanding as of September 30, 2014	116,433	$ 45.37	$ 74.63	84.10

(1) The number of options at September 30, 2013 includes 100,611 options modified in connection with the Repricing (see below).

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2014, the aggregate intrinsic value of outstanding shares was approximately $8,700,000. As of September 30, 2014, there were 102,931 options that are exercisable at a weighted average exercise price of $38.01.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2014 and 2013 is presented as follows:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at September 30, 2012	62,657	$ 50.73
Granted	18,462	62.83
Vested	(29,492)	92.53
Canceled/Forfeited	(8,435)	79.53
Nonvested at September 30, 2013 *(2)*	43,192	86.99
Granted	4,113	63.81
Vested	(29,890)	92.00
Canceled/Forfeited	(3,913)	82.72
Nonvested at September 30, 2014	13,502	$ 70.20

(2) The number of non-vested options at September 30, 2013 includes 29,930 options modified in connection with the repricing (see below).

On April 5, 2013, the Compensation Committee approved the repricing of the exercise price of all outstanding stock options as of that date. Pursuant to such resolution of the Ivy Holdings Compensation Committee, as of the effective date, all of the previously granted options were exchanged for new options with a lower exercise price granted on a one-for-one basis. As a result of this repricing, the Company repriced 49,380 vested options and 59,748 unvested options from an original exercise price of $100.00 per share to a new exercise price of $30.00 per share. Other than the exercise price, all other terms of the repriced options, such as vesting and contractual life, remained the same. The Company has accounted for the repricing as a modification and recorded any net incremental fair value related to vested awards as compensation expense on the date of modification. In addition, the Company is recording the incremental fair value related to the unvested awards, together with unamortized stock-based compensation expense associated with the unvested awards, over the remaining requisite service period of the option holders. In connection with the repriced options, the Company recorded stock compensation expense of $1,454,000 on the date of the modification. Incremental compensation cost resulting from the modification was $1,097,000 and $548,000 during the year ended September 30, 2014 and from the modification date through September 30, 2013, respectively.

The original fair value of the options granted ranges from $50.73 to $63.81 per option. In connection with the repricing, the stock compensation expense related to the stock options granted prior to April 5, 2013 is calculated based on a fair value of $97.75. The fair value was determined using the Black-Scholes option pricing model.

Fair value of the repriced options was estimated with the following assumptions for Ivy Holdings:

For the year ended September 30,	2013
Weighted average fair value of repriced options	$97.75
Estimated fair market value of the Company's common stock on the date of grant	$120.00
Weighted average expected life of the options	8.2 years
Risk-free interest rate	1.7%
Weighted average expected volatility	45.9%
Dividend yield	0.00%

Stock-Based Compensation Expense

Stock-based compensation expense for all share-based payments in exchange for employee services (including stock options and restricted stock) is measured at fair value on the date of grant, estimated using an option pricing model and is recognized in the consolidated financial statements, net of estimated forfeitures over the awards requisite service period.

The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of options granted. Estimated forfeitures will be revised in future periods if actual forfeitures differ from the estimates and will impact compensation cost in the period in which the change in estimate occurs. The determination of fair value using the Black-Scholes option-pricing model is affected by the Company's estimated stock price as well as assumptions regarding a number of complex and subjective variables, including expected stock price volatility, risk-free interest rate, expected dividends and projected employee stock option exercise behaviors.

Fair value for options granted during the years ended September 30, 2014 and 2013 was estimated with the following assumptions for Ivy Holdings:

For the years ended September 30,	2014	2013
Weighted average fair value of option grants	$ 63.81	$ 62.83
Estimated fair market value of the Company's common stock on the date of grant	$ 120.00	$ 120.00
Weighted average expected life of the options	8.0 years	8.2 years
Risk-free interest rate	2.7%	1.7%
Weighted average expected volatility	45.0%	45.9%
Dividend yield	0.00%	0.00%

Expected Term - The expected term of options granted represents the period of time that they are estimated to be outstanding.

Risk-Free Interest Rate - The Company bases the risk-free interest rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Volatility—The Company estimates the volatility of the common stock at the date of grant based on the average of the historical volatilities of a group of peer companies. The Company has identified a group of comparable companies to calculate historical volatility from publicly available data for sequential periods approximately equal to the expected terms of the option grants. In selecting comparable companies, Management considered several factors including industry, stage of development, size and market capitalization.

Forfeitures—Share-based compensation is recognized only for those awards that are ultimately expected to vest. Compensation expense is recorded net of estimated forfeitures. Those estimates are revised in subsequent periods if actual forfeitures differ from those estimates. The Company used data since May 2005 to estimate pre-vesting option forfeitures.

Stock-based compensation expense for the Ivy Holdings stock options recognized during the years ended September 30, 2014 and 2013 was approximately $2,673,000 and $3,595,000 (including the impact of the option repricing noted above), respectively. At September 30, 2014, there were 13,502 unvested options which could potentially vest over the next three fiscal years, subject to meeting various vesting requirements which include time, discretion, and various performance targets as defined. The remaining maximum estimated stock compensation expense to be amortized to expense in future periods is approximately $960,000. The stock-based compensation expense is based on a number of criteria, including time, achievement of Company and Business Unit EBITDA targets and CEO and Compensation Committee discretion. Options which are expected to vest based on CEO and Compensation Committee discretion, are treated as variable stock options and are subject to revaluation at each reporting period. Management determined the fair value of the discretionary vested options using a Black Scholes calculation but determined that the change in compensation expense was not material to the consolidated financial statements for the years ended September 30, 2013 and 2014.

Dividends

The Company distributed $100 million in connection with the issuance of the Additional 2019 Notes, during the year ended September 30, 2013, which was recorded against retained earnings, and was ultimately paid to the common stockholders of Ivy Holdings.

10. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through 2026. Certain operating leases contain rent escalation clauses and renewal options, which have been factored into determining rent expense on a straight-line basis over the lease terms. Capital leases bear interest at rates ranging from 2% to 11% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2014, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2015	$ 5,776	$ 5,772
2016	3,215	4,746
2017	2,046	3,821
2018	1,438	3,098
2019	1,217	2,142
Thereafter	7,433	2,503
Total minimum lease payments	21,125	$ 22,082
Less: amounts representing interest	(5,971)	
	15,154	
Less: current portion	(4,691)	
	$ 10,463	

Rent expense for the years ended September 30, 2014 and 2013 was approximately $9,615,000 and $7,365,000, respectively. Sublease rental income of approximately $271,000 and $209,000, for the years ended September 30, 2014 and 2013, respectively, was recorded as a reduction to rental expense.

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

Following the acquisition of the Company in August 2010, two putative class action complaints were filed against the Company, each of the Company's special committee members, Ivy Holdings, LGP, and certain other parties. These complaints, which were consolidated into a single action, allege generally

that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties, in connection with the transaction with the Company by, among other things, authorizing the transaction for what plaintiffs claim to be inadequate consideration and pursuant to what plaintiffs claim to be an inadequate process and with inadequate disclosures. An amended complaint was filed in July 2011 alleging the same general facts.

On December 30, 2010, another lawsuit was filed in Delaware Chancery Court by Terrier Partners and five related entities against the same defendants identified above. The complaint alleges generally that the consideration offered to shareholders in connection with the transaction with the Company was inadequate in light of the revenue received under AB 1383 (see California Hospital Fee Program below), and that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties by not obtaining a higher price in light of this additional revenue.

In May 2012, the Court of Chancery granted motions to consolidate the Terrier Partners case and the class action cases, and for class certification, certifying the class as a non-opt out class. The Court also entered a schedule permitting the plaintiffs to file a new amended complaint, and on June 11, 2012, plaintiffs filed their Verified Consolidated Third Amended Class Action Complaint. On July 26, 2012, the director defendants answered the Third Amended Complaint. That same day, Prospect moved to dismiss itself as a party to the Third Amended Complaint. The Court granted the motion to dismiss the Company as a defendant, leaving only the individuals as defendants in the case.

The parties subsequently engaged in discovery, and agreed to stay the matter in order to explore the possibility of mediation, which was unsuccessful. The defendants have vigorously defended the matter, and will continue to do so. No trial date is currently set.

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

Seismic Standards

Our SCHS Hospitals and Alta Los Angeles Hospitals are required to comply with California's Alfred E. Alquist Hospital Facilities Seismic Safety Act (the "Alquist Act"), which regulates the seismic performance of all aspects of hospital facilities in California. The Alquist Act imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and the retrofitting or replacement of medical facilities to comply with current seismic standards. The Alquist Act also requires that the California Building Standards Commission adopt earthquake performance categories, seismic evaluation procedures, standards and timeframes for upgrading certain facilities, and seismic retrofit building standards. These regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. The Building Standards Commission completed its adoption of evaluation criteria and retrofit standards in 1998.

The Alquist Act requires that within three years after the Building Standards Commission had adopted evaluation criteria and retrofit standards:

- Hospitals in California must conduct seismic evaluation and submit these evaluations to the Office of Statewide Health Planning and Development ("OSHPD"), Facilities Development Division for its review and approval;

- Hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and

- Hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

The Company was required to conduct engineering studies at its hospitals to determine whether and to what extent modifications to the hospital facilities will be required. Management believes that SCH Culver City meets all current requirements; however, it may be required to make significant capital expenditures in the future to comply with the seismic standards, which could impact its earnings. The cost at September 30, 2014, is unknown at this time but could be material. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

The OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as Structural Performance Category ("SPC") 1. These buildings are considered hazardous and at risk of collapse in the event of an earthquake and they were required to be retrofitted, replaced or removed from providing acute care services by 2013, unless granted an extension. OSHPD is using HAZARDS U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings and those that are determined to pose a low seismic risk may be reclassified to SPC-2. The SPC-2 buildings would have until 2030 to comply with the structural seismic safety standards. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 building(s) re-evaluated. Applications for a HAZUS re-evaluation of the seismic risk were submitted for SCH Hollywood, SCH Culver City and Los Angeles Community Hospital, but there is no assurance they will result in extensions.

In addition, in 2011, the California Legislature enacted Senate Bill 90, which permitted some hospitals to apply for up to an additional seven year extension to the seismic retrofit deadlines, not to extend beyond January 1, 2020. SB 90 also permits OSHPD to extend until January 1, 2018 the date by which the hospitals must obtain a building permit and commence the required retrofit project.

SCH Culver City and Los Angeles Community Hospitals both applied for the SB 90 extension from OSHPD. Two of the buildings owned by SCH Culver City were granted SB 90 extensions until January 2019 and July 2019, respectively. Also, the facility operated by Los Angeles Community Hospital received an SB 90 extension until January 2019. All three extensions are contingent upon the delivery of certain additional plans and reports prior to January 2015 that have either been delivered or are in process at the time of this report. OSHPD is still reviewing the SB 90 extension request filed for a third building owned by SCH Culver City, which is also still subject to our application to be reclassified as a SPC-2 building.

OSHPD has discretion to approve or disapprove SB 90 extension requests, and to determine the length of the extension (up to the maximum seven years), based on eligibility factors including seismic risks associated with the affected buildings (which can be impacted by the updated HAZUS findings), community access to essential hospital services in the area and financial hardships facing the applicant.

Effective May 6, 2014, Prospect acquired the hospital facilities NSH and LACH Bellflower (see Note 4). For the newly acquired facilities, the Company is in the process of pursuing Non-Structural Performance Category ("NPC") 2 classification and the extension of the compliance deadlines that would result.

These requirements can result in significant operational changes and capital outlays. Management is continuing to assess its options and the methods of financing the required retrofits. Based on management's evaluation, the costs of renovation needed to comply with the California seismic safety standards for its acute-care facilities, including asbestos abatement, are not estimable at this time.

Legislation and HIPAA

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

The Company believes that it is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

California Hospital Fee Program

The State of California enacted Assembly Bill 1383 ("AB 1383") effective January 1, 2010, as amended by Assembly Bill 1653 (collectively, the "Program"), to provide supplemental payments to certain hospitals such as the hospitals owned and operated by the Company's subsidiaries. The Program requires participating hospitals to pay fee assessments into a pool of funds to which the federal government contributes matching funds. Most of these funds, including the federal matching funds, are then distributed to qualifying hospitals. In addition, on April 13, 2011 SB 90 was signed into law and provided for a six-month extension of the Hospital Fee Program for dates of service from January 1, 2011 through June 30, 2011. CMS granted final approval of SB 90 on December 29, 2011, at which point the revenue and expense was recognized for the retroactive period. In September 2011, the State of California enacted Senate Bill 335 ("SB 335") which provides a 30-month hospital fee program for dates of service from July 1, 2011 through December 31, 2013. The elements of SB 335 related to the fee for service payments were approved by CMS on June 22, 2012. The payments due under the managed care component are scheduled to be made in three cycles. The first two cycles were previously approved by CMS, and the third cycle was approved by CMS subsequent to September 30, 2014. Certain technical changes to the legislation required by CMS are included in Senate Bill 920.

Governor Brown signed Senate Bill 239 ("SB 239") in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. This program was approved by CMS on December 5, 2014. SB 239 provides that the hospital fee program will continue through December 31, 2022 in three year cycles and will require authorization of each cycle by the California legislature. The Company has not recognized any amounts related to SB 239 as of and for the years ended September 30, 2014 and 2013.

For the years ended September 30, 2012 and 2011, SCH Culver City received invoices for fee assessments under AB 1383 and SB 90 of approximately $6,310,000 and $19,000,000, respectively, following payment of which, SCH Culver City was scheduled to receive approximately $5,236,000 and $15,000,000, respectively. Management of SCH Culver City estimated that SCH Culver City would be a "net" payer under the Program, since the fee assessments on SCH Culver City exceeded the supplemental payments by approximately $1,074,000 and $4,000,000, respectively. Accordingly, on October 6, 2010, the Company notified the California Department of Healthcare Services ("DHCS") that SCH Culver City was opting out of the Program.

SCH Culver City did not pay the required fee assessments under the Program. Beginning February 14, 2011, the DHCS began withholding against amounts otherwise due SCH Culver City, in the amount of $65,000 per week indicating that withholdings would continue for 108 weeks and would total approximately $7,000,000. Through September 30, 2012, a total of approximately $2,986,000 had been withheld against SCH Culver City's Medi-Cal fee-for-service payments. As of September 30, 2012, SCH Culver City recorded a liability of approximately $5,494,000, representing the accrued loss above, as well as deferred recognition of payments received from managed care plans. On November 15, 2012 the Company entered into a settlement agreement with DHCS with regards to SCH Culver City's liability under AB 1383, SB 90 and SB 335, as discussed above. Under the terms of the agreement, the DHCS agreed to forgive approximately $2,000,000 of the fees due under AB 1383, which was recorded by the Company during the year ended September 30, 2013. The remaining liability due to DHCS of $4,605,000 will be repaid by the Company monthly over a 10-year period without interest or penalties. The Company recorded a net liability of $3,233,000 as of the settlement date, which represents the net present value of the liability due to DHCS discounted at an effective interest rate of 7.5%. As of September 30, 2014 and 2013, the unamortized balance of the liability amounted to $2,806,000 and $3,046,000, respectively. The DHCS will no longer withhold against any other amounts due to SCH Culver City unless the Company is delinquent on payments owed under the agreement.

As of September 30, 2013, the Company had a receivable related to the California Hospital Fee Program of $18,895,000 in the accompanying consolidated balance sheets. The Company did not have a receivable related to the California Hospital Fee Program as of September 30, 2014. As of September 30, 2014 and 2013, the Company had a liability related to the California Hospital Fee Program of $2,806,000 and $8,609,000, respectively, in the accompanying consolidated balance sheets.

Total California Hospital Fee program revenues and expenses recognized during the years ended September 30, 2014 and 2013 were as follows (in thousands):

Year Ended September 30,	2014	2013
Hospital services revenues	$ 11,884	$ 63,371
Hospital operating expenses	5,863	37,925
Net pre-tax impact	$ 6,021	$ 25,446

Collective Bargaining Agreements

A small group of employees at SCH Hollywood, which is one of the hospitals under the consolidated group of Alta Hospitals System, LLC, and Service Employees International Union, United Healthcare Workers-West ("SEIU") are currently parties to a collective bargaining agreement with a termination date of April 27, 2017. In addition, approximately 77% of the employees of SCH Culver City are part of a collective bargaining agreement with the SEIU or the California Nurses Association ("CNA"). SCH Culver City and CNA are currently parties to a collective bargaining agreement that expires on December 21, 2015. SEIU and SCH Culver City are currently parties to a three-year term agreement that expires on April 27, 2017.

As of September 30, 2014, approximately 25% of the employees at CharterCARE St. Joseph's are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expires July 31, 2016. An additional 1% are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires April 30, 2016.

Tangible Net Equity ("TNE") requirement

The Company's affiliated physician organizations must comply with a minimum working capital requirement, Tangible Net Equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the California Department of Managed Health Care. TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. At September 30, 2014 and 2013, the Company and the affiliated physician organizations were in compliance with these regulatory requirements.

Employee Health Plans

From October 1, 2012 through December 31, 2012, the Company (except for SCH Culver City and Nix Health) was fully insured for its HMO and PPO plans to employees. For the fully insured groups, health benefits were administered by a commercial insurance carrier, based on plan coverage and eligibility guidelines determined by the Company. The insurance policies had guaranteed cost and the Medical Group and Corporate segment incurred no claim liability if terminated. SCH Culver City and Nix were self-insured for their EPO/HMO and PPO plans.

Effective January 1, 2013 the Company offered self-insured EPO/HMO and PPO plans to all eligible employees. The CharterCARE hospitals were not included under such plans from the date of acquisition through September 30, 2014 and have a separate low-deductible plan. Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). A commercial insurance policy covers losses in excess of $250,000 per occurrence for the Hospital Segment and $175,000 for the Medical Group and Corporate segments. An actuarially estimated liability of approximately $1,828,000 and $1,788,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2014 and 2013, respectively.

Provider Contracts

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

11. Defined Contribution Plan

The Company sponsors a defined contribution plan covering substantially all employees who meet certain eligibility requirements. Under this plan, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plan, except at Nix Health and PCC, for which the expense for the employer match was $576,000 and $463,000 for the years ended September 30, 2014 and 2013, respectively. Total expenses under the plan were approximately $197,000 and $87,000 during the years ended September 30, 2014 and 2013, respectively.

12. Accrued Medical Claims and Other Healthcare Costs Payable

The following table presents the roll-forward of incurred but not reported ("IBNR"), claims reserves (Medical Group and full risk contracts) as of and for each of the fiscal years ended September 30, 2014 and 2013 (in thousands):

September 30,	2014	2013
IBNR as of beginning of year	$ 30,352	$ 26,985
Claim expenses incurred during the year:		
Related to current year	161,088	128,747
Related to prior year	(3,571)	(3,646)
Total incurred	157,517	125,101
Claims paid during the year:		
Related to current year	(124,393)	(100,301)
Related to prior year	(24,162)	(21,433)
Total paid	(148,555)	(121,734)
IBNR as of end of year	$ 39,314	$ 30,352

Following is a table showing the details of the medical group cost of revenues per the consolidated statements of operations (in thousands):

Years Ended September 30,	2014	2013
Capitation expense	$ 85,754	$ 76,918
Fee-for-service claims expense	94,749	82,846
Other physician compensation	5,066	3,993
Other cost of revenues	(227)	700
Total cost of revenues	$ 185,342	$ 164,457

13. Joint Venture

The Company (through Prospect Medical Group, Inc.) and an unrelated third party, AMVI Care Health Network, Inc. ("AMVI") are partners in a joint venture initially formed to service Medi-Cal members under the CalOptima program in Orange County, California. Healthy Families and OneCare members were subsequently added to the joint venture arrangement. Effective January 1, 2013, all Healthy Family participants were transferred to the Company's Medi-Cal line of business and therefore no longer part of the joint venture. The Company does not consolidate the joint venture. The Company includes in its consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to it, together with the management fee that it charges the joint venture partner for managing those enrollees specifically assigned to AMVI. Costs incurred by the Company in managing the joint venture are included in general and administrative expenses in the accompanying consolidated financial statements. As of September 30, 2014 and 2013, the net liability balances of the Company investment in the joint venture under the equity method were approximately $1,594,000 and $2,000,000, respectively, and were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

Summarized unaudited financial information for the unconsolidated joint venture as of and for each of the years ended September 30, 2014 and 2013 is as follows (in thousands):

September 30,	2014	2013
Cash	$ 1,753	$ 742
Receivables	2,232	2,037
Total assets	$ 3,985	$ 2,779
Accrued medical claims	$ 1,658	$ 1,556
Other payables	1,470	34
Other partner's capital	856	1,188
Prospect's capital	1	1
Total liabilities and partner's capital	$ 3,985	$ 2,779

Years Ended September 30,	2014	2013
Revenues	$ 19,289	$ 16,307
Income before income taxes	$ 2,915	$ 2,206
Prospect's equity income	$ 3,295	$ 2,150
Management fees earned by Prospect	$ 1,141	$ 1,016

14. Segment Information

The Company's operations are organized into three reporting segments: (i) Hospital Services – which is comprised of the Alta Hospitals, SCH Culver City, Nix Health, and PCC reporting units, owns 13 hospitals or extended care facilities – Los Angeles Community Hospital, Norwalk Community Hospital, Los Angeles Community Hospital at Bellflower, Newport Specialty Hospital, SCH Hollywood, SCH Van Nuys, SCH Culver City, Nix Medical Center, Nix Specialty Health Center, Nix CGH, Roger Williams Medical Center, Saint Joseph's Health Services of Rhode Island, and Elmhurst Extended Care; (ii) Medical Group – which is comprised of the Prospect and ProMed reporting units, provides management services to affiliated physician organizations that operate as independent physician associations or medical practice groups and certain unaffiliated independent physician associations; and (iii) Corporate, which represents expenses incurred in Prospect Medical Holdings, Inc., that were not allocated to the other reporting segments.

The accounting policies of the reporting segments are the same as those described in the summary of significant accounting policies (see Note 2). The Company evaluates financial performance and allocates resources primarily based on earnings from operations before interest expense, interest income, income taxes, depreciation and amortization, as well as income or loss from operations before income taxes, excluding infrequent or unusual items.

The reporting segments are strategic business units that offer different services within the healthcare industry. Business in each reporting segment is conducted by one or more direct or indirect wholly-owned subsidiaries of the Company and certain affiliated physician organizations controlled through assignable option agreements and management services agreements. The Company voluntarily discloses the following table which summarizes certain information for each of the reporting segments regularly provided to and reviewed by the chief operating decision maker (in thousands):

	As of and for the Year Ended September 30, 2014				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 600,536	$ 253,980	$ -	$ -	$ 854,516
Intersegment revenues	-	1,039	-	(1,039)	-
Total revenues	600,536	255,019	-	(1,039)	854,516
Depreciation and amortization	20,694	2,846	40	-	23,580
Operating income (loss)	57,748	29,080	(20,676)	-	66,152
Other (income) expense	(3,037)	(26)	38,480	1,622	37,039
Income (loss) before income taxes	60,785	29,106	(59,156)	(1,622)	29,113
Provision for income tax	-	-	10,561	-	10,561
Net income (loss)	$ 60,785	$ 29,106	$ (69,717)	$ (1,622)	$ 18,552
Identifiable segment assets	$ 599,516	$ 75,612	$ 86,189	$ -	$ 761,317
Segment capital expenditures, net of dispositions	$ 49,181	$ 924	$ 2	$ -	$ 50,107
Segment goodwill	$ 136,525	$ 22,339	$ -	$ -	$ 158,864

	As of and for the Year Ended September 30, 2013				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 491,839	$ 221,743	$ -	$ -	$ 713,582
Intersegment revenues	-	727	-	(727)	-
Total revenues	491,839	222,470	-	(727)	713,582
Depreciation and amortization	14,062	2,715	37	-	16,814
Operating income (loss)	75,199	24,399	(17,442)	-	82,156
Other (income) expense	1,314	(49)	37,839	-	39,104
Income (loss) before income taxes	73,885	24,448	(55,281)	-	43,052
Provision for income tax	-	-	9,810	-	9,810
Net income (loss)	$ 73,885	$ 24,448	$ (65,091)	$ -	$ 33,242
Identifiable segment assets	$ 453,232	$ 117,556	$ 8,158	$ -	$ 578,946
Segment capital expenditures, net of dispositions	$ 13,583	$ 650	$ 50	$ -	$ 14,283
Segment goodwill	$ 136,526	$ 22,338	$ -	$ -	$ 158,864

(1) Prospect files consolidated tax returns and allocates costs for shared services and corporate overhead to each of the reporting segments. With the exception of Nix Health and PCC, all debt, including debt related to the Medical Group and Hospital Services segment, is recorded at the Parent Entity level. The Company does not allocate interest expense related to acquisition debt to the operating segments.

(2) Prospect Medical Group, Inc. (which serves as a holding company for the other affiliated physician organizations) files consolidated tax returns. The Medical Group segment includes the results for NGMA from October 1, 2012 (acquisition date) through September 30, 2014.

(3) The Hospital Services segment includes the results for Nix CGH, Los Angeles Community Hospital at Bellflower and Newport Specialty Hospital, and CharterCARE from the acquisition dates of April 16, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014. Included in revenues from external customers are $14,525,000 and $7,700,000 of other revenues related primarily to the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases for the years ended September 30, 2014 and 2013, respectively.

15. Subsequent Events (Unaudited)

The Company has evaluated subsequent events through December 17, 2014, the date the Company's consolidated financial statements were available for issuance.

Acquisitions

Effective October 21, 2014, the Company, through its subsidiary, Prospect CharterCARE Physicians, LLC ("PCCP"), entered into two separate asset purchase agreements pursuant to which PCCP will acquire substantially all of the assets of physician medical practices located in Rhode Island.

Pursuant to the first purchase agreement, PCCP will acquire substantially all of the assets of Physicians of Rhode Island Medical Enterprises, Inc., a primary care practice group with one physician and five nurse practitioners located in Cumberland, Rhode Island, and PMA, LLC, a primary care practice group with one physician and one nurse practitioner located in Pawtucket, Rhode Island. Pursuant to the same purchase agreement, on October 21, 2014, PCCP acquired 49% of the issued and outstanding membership interests in Partners in Clinical Research, LLC, a clinical research business located in Cumberland, Rhode Island. The Company paid $2,410,000 as consideration under the asset purchase agreement.

Pursuant to the second purchase agreement, PCCP will acquire substantially all of the assets of Physicians of East Side Primary Care, LLC, a primary care practice group with one physician, two physician assistants and one nurse practitioner located in Providence, Rhode Island. The Company paid $860,000 as consideration under this asset purchase agreement. Additionally, on each of the first four (4) anniversaries of the October 21st closing date, the Company will pay to the seller an EBITDA bonus based on the performance of the acquired practice.

The majority of the assets of the groups were acquired on October 21, 2014. However, the acquisition of certain professional licenses and related assets, and the employment of certain professional staff, will occur at a later date after all necessary licensing and credentialing by PCCP has occurred. PCCP and the sellers of the groups have entered into Interim Administrative Services Agreements that will provide for the administration of the seller entities during the period prior to such second acquisition dates. PCCP and the two physicians that are the principal owners of the seller entities have entered into employment agreements and non-compete restrictions. Additionally, PCCP entered into three (3) separate office leases with five (5) year terms that provide for the lease of the spaces currently occupied by the practices. The lessors under each office lease are the employed physicians that are the former principal owners of the groups.

California Hospital Fee Program

Governor Brown signed SB 239 in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. The fee for service component of the program was approved by CMS on December 5, 2014, and the managed care component has not yet been approved. The Company has not recognized any amounts related to SB 239 as of and for the year ended September 30, 2014. The Company anticipates a net benefit from the program for service periods from January 1, 2014 to December 31, 2016.

EXHIBIT Q8-2

PMH FISCAL YEAR 2015 2ND QUARTER UNAUDITED FINANCIAL STATEMENTS

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands, except par value and share amounts)

	June 30, 2015 (unaudited)	September 30, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 34,708	$ 39,072
Restricted cash	4,298	4,976
Investments, primarily restricted money market funds	1,266	642
Patient accounts receivable, net of allowance for doubtful accounts of $53,724 and $49,727	143,810	123,733
Due from government payors	55,100	42,518
Other receivables	24,425	15,947
Income taxes receivable, net	3,685	57
Deferred income taxes, net	68,304	68,304
Inventories	12,373	10,448
Hospital fee program receivable	24,011	-
Prepaid expenses and other current assets	20,674	14,317
Total current assets	392,654	320,014
Property, improvements and equipment, net	237,923	229,474
Deferred financing costs, net	7,789	9,457
Goodwill	161,461	158,864
Intangible assets, net	31,454	35,274
Other assets	9,341	8,234
Total assets	$ 840,622	$ 761,317
LIABILITIES AND STOCKHOLDER'S EQUITY (DEFICIT)		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 50,633	$ 39,314
Accounts payable and other accrued liabilities	94,467	88,218
Accrued salaries, wages and benefits	59,424	53,808
Hospital fee program liability	13,623	2,806
Due to government payors	36,428	26,584
Income taxes payable, net	6,120	5,879
Revolving line of credit	20,000	20,000
Current portion of capital leases	3,285	4,691
Current portion of long-term debt	568	133
Other current liabilities	1,481	1,659
Total current liabilities	286,029	243,092
Long-term debt, net of current portion	422,464	421,755
Deferred income taxes, net	70,447	70,447
Malpractice reserves	6,619	4,590
Capital leases, net of current portion	9,096	10,463
Asset retirement obligations	4,514	4,310
Other long-term liabilities	6,632	7,866
Total liabilities	805,801	762,523
Commitments, Contingencies and Subsequent Events		
Stockholder's equity (deficit):		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at June 30, 2015 and September 30, 2014	1	1
Additional paid-in capital	20,647	18,457
Retained earnings (Accumulated deficit)	3,565	(28,481)
Total Prospect Medical Holdings, Inc.'s stockholder's equity (deficit)	24,213	(10,023)
Noncontrolling interest	10,608	8,817
Total stockholder's equity (deficit)	34,821	(1,206)
Total liabilities and stockholder's equity (deficit)	$ 840,622	$ 761,317

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited, in thousands)

	Three Months Ended June 30,		Nine Months Ended June 30,	
	2015	2014	2015	2014
Revenues:				
Net Hospital Services revenues	$ 238,378	$ 131,472	$ 760,537	$ 383,183
Medical Group revenues	91,018	69,575	235,945	181,795
Net Global Risk Management revenues	813	-	1,389	-
Other revenues	690	1,485	5,465	2,603
Total net revenues	330,899	202,532	1,003,336	567,581
Operating expenses:				
Hospital operating expenses	185,976	102,517	594,046	291,154
Medical Group cost of revenues	52,613	47,121	161,679	134,385
Global Risk Management operating expenses	710	-	1,152	-
General and administrative	49,172	32,864	143,064	86,095
Depreciation and amortization	8,676	5,488	25,212	15,481
Total operating expenses	297,147	187,990	925,153	527,115
Operating income from unconsolidated joint ventures	3,119	1,001	4,133	1,604
Operating income	36,871	15,543	82,316	42,070
Other (income) expense:				
Interest expense and amortization of deferred financing costs, net	10,491	10,282	31,535	30,946
Gain on bargain purchase adjustment	-	(4,068)	318	(4,068)
Other (income) expense	(25)	(50)	(71)	61
Total other expense, net	10,466	6,164	31,782	26,939
Income before income taxes	26,405	9,379	50,534	15,131
Income tax provision	9,579	3,403	18,464	5,934
Net income	16,826	5,976	32,070	9,197
Net income attributable to noncontrolling interest	268	1,489	26	1,503
Net income attributable to Prospect Medical Holdings, Inc.	$ 16,558	$ 4,487	$ 32,044	$ 7,694

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)

	Nine Months Ended June 30,	
	2015	2014 (1)
Operating activities		
Net income	$ 32,070	$ 9,197
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	25,212	15,481
Amortization of deferred financing costs, net	1,668	1,662
Amortization of original issue (premium) discount	810	810
Provision for bad debts	34,634	25,258
Stock-based compensation	2,018	2,018
Undistributed earnings from equity method investments	(172)	-
Gain on sale of assets	(25)	-
Gain on bargain purchase adjustment	318	(4,068)
Gain on sale of equity method investment	(296)	-
Change in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(65,322)	(39,655)
Due to/from government payors, net	(2,737)	(2,876)
Prepaid expenses and other current assets	(1,885)	(2,503)
Hospital fee program receivable	(24,011)	18,895
Hospital fee program liability	10,817	(5,733)
Inventories	(1,927)	17
Income taxes receivable/payable, net	(3,387)	(10)
Deposits and other assets	(33)	298
Accrued medical claims and other healthcare costs payable	11,319	6,852
Accounts payable and other accrued liabilities	13,243	3,937
Net cash provided by operating activities	32,314	29,579
Investing activities		
Purchases of property, improvements and equipment	(28,517)	(41,141)
Proceeds from sale of property and improvements	987	-
Cash paid for acquisitions, net of cash received and working capital adjustment	(895)	(58,300)
Cash paid for equity method investment	(1,880)	(1,100)
Proceeds for partial disposition of equity method investment	1,233	-
Collections from note receivable	52	674
Increase in restricted investments	(624)	(5)
Issuance of note receivable	-	(625)
Net cash (used in) investing activities	(29,644)	(100,497)
Financing activities		
Repayments of long-term debt	(100)	(127)
Borrowings on line of credit, net	-	40,000
Repayments of capital leases	(3,685)	(3,945)
Cash paid for deferred financing costs, net	-	(50)
Change in restricted cash	678	(2,423)
Proceeds from exercises of stock options and warrants	172	-
Repayments of insurance premiums financing	(4,099)	(1,628)
Other, net	-	(17)
Net cash (used in) provided by financing activities	(7,034)	31,811
(Decrease) in cash and cash equivalents	(4,364)	(39,108)
Cash and cash equivalents at beginning of period	39,072	86,315
Cash and cash equivalents at end of period	$ 34,708	$ 47,207

Continued at next page

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)
(continued)

	Nine Months Ended June 30,	
	2015	2014
Supplemental disclosure of cash flow information:		
Interest paid	$ 37,545	$ 36,927
Income taxes paid, net	$ 21,777	$ 6,179
Schedule of non-cash investing and financing activities:		
Equipment acquired under capital leases	$ 905	$ 1,892
Insurance premium financed	$ 4,472	$ 2,122
Long-term liability assumed from acquisition of CharterCARE	$ -	$ 6,440

(1) Certain reclassifications were made to the fiscal 2014 presentation in order to conform to the fiscal 2015 presentation.

EXHIBIT Q10-1: INDEPENDENT FOUNDATION CERTIFICATE OF INCORPORATION (DRAFT)

CERTIFICATE OF INCORPORATION

OF

[NAME OF POST-CONVERSION FOUNDATION]

The undersigned incorporator hereby forms a corporation under the Connecticut Revised Nonstock Corporation Act, Chapter 602 of the Connecticut General Statutes (as the same may hereafter be revised or replaced, the "Nonstock Act"), as follows:

1. *Name.* The name of the Foundation is [NAME OF POST-CONVERSION FOUNDATION] (the "Foundation").

2. *No Members.* The Foundation shall have no members.

3. *Purposes.* The Foundation shall be operated exclusively for charitable, religious, educational, and/or scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding section of any future federal tax code, as amended (the "Code" and referred to by Section reference). That benefit, further, support and carry out the purposes, missions and objectives of [insert WH Service Area municipalities and public charities](the "Supported Organizations") to the extent such purposes, missions and objectives exclusively support or promote the following purposes:

(a) To provide for the healthcare needs of the greater Waterbury area, including the towns of Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown, Wolcott and Woodbury (the "Communities");

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

(c) To support and engage in community projects, grants, activities and programs that will improve access to healthcare and enhance the health of the Communities, including the provision of preventive health programs and health education, education and training of healthcare providers and educators in the Communities; and

(d) In furtherance of the foregoing activities and purposes, but subject to the restrictions of this Certificate of Incorporation, the Foundation may engage in any lawful act or activity for which nonstock corporations may be formed under the Nonstock Act.

4. *Nonprofit.* The Foundation is nonprofit and shall not have or issue shares of stock or make distributions unless as expressly provided herein.

5. *Restrictions.* The Foundation shall (i) be empowered only to engage in activities in furtherance of the above-described exclusively charitable, religious, educational and/or scientific

purposes, and (ii) not be empowered to engage in activities that would cause the Foundation to cease to be qualified as exempt under Section 501(a) of the Code as described in Section 501(c)(3) of the Code, or that would cause contributions to the Foundation to cease to be deductible under Section 170(c)(2) of the Code. The Foundation shall be subject to the following additional restrictions and requirements:

(a) The Foundation shall not participate in or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. No substantial part of the activities of the Foundation shall constitute the carrying on of propaganda or otherwise attempting to influence legislation, except to the extent the Foundation makes expenditures for purposes of influencing legislation in conformity with the requirements of Section 501(h) of the Code.

(b) For any period during which it is a "private foundation," as defined in Section 509 of the Code, the Foundation shall distribute its income for each taxable year at such time and in such manner as not to become subject to the tax on undistributed income imposed by Section 4942 of the Code. Among the activities in which the Foundation shall not engage for any period during which it is such a "private foundation" are: (i) any act of self-dealing (as defined in Section 4941(d) of the Code); (ii) retaining any excess business holdings (as defined in Section 4943(c) of the Code); (iii) making any investment in such manner as to subject the Foundation to tax under Section 4944 of the Code; and (iv) making any taxable expenditures (as defined in Section 4945(d) of the Code).

(c) No part of the net earnings of the Foundation shall inure to the benefit of, or be distributable to, its officers, directors, trustees or other private persons, except that the Foundation shall be authorized and empowered to pay reasonable compensation for services rendered, to reimburse reasonable expenses incurred, to purchase goods and services at reasonable prices, and to provide programs, services and other benefits, all in furtherance of the exclusively charitable, religious, educational, and/or scientific purposes of the Foundation set forth in Section 3, and to make distribution of its assets upon dissolution as provided for in Section 9.

6. *Board of Trustees.* All corporate powers shall be exercised by or under the authority of, and the activities, property and affairs of the Foundation shall be managed by or under the direction of its Board of Trustees as set forth in the Bylaws of the Foundation. At least a majority of the Board of Trustees shall be comprised of individuals appointed to the Board of Directors by the Supported Organizations. In the event that a supported Organization ceases to be exempt under Section 501(c)(3) of the Code or becomes a private foundation under section 509(a) of the Code shall immediately cease to be a "Supported Organization" of the Foundation and shall have no rights or powers with respect to the Foundation. A Trustee appointed by any such Supported Organization shall immediately be disqualified and removed from the Board of Trustees.

7. *Limitation of Liability of Trustees to the Foundation.*

(a) Liability Limited. To the fullest extent that the Nonstock Act or any other law of the State of Connecticut, as in effect on the date of this Certificate of Incorporation or as hereafter amended, permits the limitation or elimination of the personal liability of a Trustee of the Foundation to the Foundation, no Trustee shall be liable to the Foundation for monetary damages for breach of duty as a Trustee.

(b) Effect of Limitation. No repeal, modification or amendment of this Section 7 shall adversely affect any right or protection of a Trustee of the Foundation existing at the time of such repeal or modification. Nothing contained in this Section 7 shall be construed to deny to the Trustees of the Foundation the benefit of Section 52-557m of the Connecticut General Statutes as in effect at the time of the violation (or the corresponding provisions of any subsequent statute amending or replacing said statute), if applicable. The provisions of this Section 7 are set forth in this Certificate of Incorporation pursuant to the authority contained in subdivision (4) of subsection (b) of Section 33-1026 of the Nonstock Act and are intended to limit the liability of Trustees of the Foundation to the greatest extent now or hereafter permitted under the laws of the State of Connecticut.

8. *Indemnification of Trustees and Officers; Prepayment of Expenses.*

(a) Right to Indemnification. The Foundation shall indemnify and hold harmless, to the fullest extent permitted by applicable law as it presently exists or may hereafter be amended, any person (an "Indemnitee") who was or is made or is threatened to be made a party to or is otherwise involved in any action, suit or proceeding, whether civil, criminal, administrative or investigative (a "Proceeding"), by reason of the fact that he or she, or a person for whom he or she is a legal representative, is or was a Trustee or officer of the Foundation, or while a Trustee or officer of the Foundation, is or was serving at the request of the Foundation as a director, trustee, officer, employee or agent of another corporation or of a partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity, including service with respect to employee benefit plans, against all liability (as defined in Section 33-1116 of the Nonstock Act) and loss suffered by such Indemnitee for any action taken, or any failure to take any action, by the Indemnitee. Notwithstanding the preceding sentence, except as otherwise provided in paragraph (c) of this Section 8, the Foundation shall be required to indemnify an Indemnitee in connection with a Proceeding (or part thereof) commenced by such Indemnitee only if the commencement of such Proceeding (or part thereof) by the Indemnitee was authorized by the Board of Trustees of the Foundation.

(b) Prepayment of Expenses. Subject to the last sentence of paragraph (a) of this Section 8, the Foundation shall pay the expenses (including attorneys' fees) incurred by an Indemnitee in defending any Proceeding in advance of its final disposition; provided, however, that, to the extent required by law, such payment of expenses in advance of the final disposition of the Proceeding shall be made only upon receipt of (1) a written affirmation of the Indemnitee as required under Section 33-1119 of the Nonstock Act and (2) an undertaking by the Indemnitee to repay all amounts advanced if it should be ultimately determined that the Indemnitee is not entitled to be indemnified under this Section 8 or otherwise.

(c) Claims. Subject to the last sentence of paragraph (a) of this Section 8, if a claim for indemnification or payment of expenses under this Section 8 is not paid in full within sixty (60) days after a written claim therefor by the Indemnitee has been received by the Foundation, the Indemnitee may file suit to recover the unpaid amount of such claim and, if successful in whole or in part, shall be entitled to be paid the expense of prosecuting such claim. In any such action, the Foundation shall have the burden of proving that the Indemnitee is not entitled to the requested indemnification or payment of expenses under applicable law.

(d) Nonexclusivity of Rights. The rights conferred on any Indemnitee by this Section 8 shall not be exclusive of any other rights which such Indemnitee may have or hereafter acquire under this Certificate of Incorporation or any statute, agreement, bylaw, vote of disinterested Trustees or otherwise.

(e) Other Sources. The Foundation's obligation, if any, to indemnify or to advance expenses to any Indemnitee who was or is serving at its request as a director, officer, employee or agent of another corporation, partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity shall be reduced by any amount such Indemnitee may collect as indemnification or advancement of expenses from such other Foundation, partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity.

(f) Amendment or Repeal. Any repeal or modification of the foregoing provisions of this Section 8 shall not adversely affect any right or protection hereunder of any Indemnitee in respect of any act or omission occurring prior to the time of such repeal or modification.

(g) Other Indemnification and Prepayment of Expenses; Employees. This Section 8 shall not limit the right of the Foundation, to the extent and in the manner permitted by law, to indemnify and to advance expenses to persons other than Indemnitees when and as authorized by appropriate corporate action. Without limiting the effect of the foregoing sentence, the Foundation may, if specifically authorized by the Board of Trustees of the Foundation, indemnify and advance expenses to any person who is made a party to or is otherwise involved in a proceeding by reason of the fact that he or she, or a person for whom he or she is a legal representative, is or was an employee of the Foundation, or while an employee of the Foundation, is or was serving at the request of the Foundation as a director, trustee, officer, employee or agent of another corporation or of a partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity, including service with respect to employee benefit plans, against all liability (as defined in Section 33-1116 of the Nonstock Act) and loss suffered by such employee for any action taken, or any failure to take any action, by such employee, to the greatest extent permitted by applicable law.

(h) Interpretation. The provisions of this Section 8 are set forth in this Certificate of Incorporation pursuant to the authority contained in subdivision (5) of subsection (b) of Section 33-1026 of the Nonstock Act and are intended to expand the scope of, and make obligatory on the Foundation, the indemnification of Trustees and officers of the Foundation to the greatest extent now or hereafter permitted under the laws of the State of Connecticut, and to make permissible for the Foundation the indemnification of employees to the greatest extent permitted by applicable law.

(i) Limitation. Notwithstanding any other provision of this Section 8, if at any time the Foundation is a "private foundation," as defined in Section 509 of the Code, the Foundation shall not, during the period it is such a private foundation, indemnify any person if such indemnity or its carrying out will constitute a violation of any provision of Section 33-281(b) of the Connecticut General Statutes or any substantially like provision which may be contained in this Certificate of Incorporation.

9. *Dissolution.* Upon dissolution of the Foundation, the Board of Trustees shall adopt a plan of distribution which shall, after paying or making provision for payment of the liabilities of the Foundation, cause all of the net assets of the Foundation to be distributed to one or more organizations that are described in Section 501(c)(3) of the Code and that are exempt under Section 501(a) of the Code and are established for purposes substantially similar to those of this Foundation as the plan of distribution, adopted in accordance with law, shall provide. Such organization(s) shall be selected by the Superior Court of New Haven County after notice to the Attorney General of the State of Connecticut.

10. *References to Laws.* References to Sections of the 1986 Internal Revenue Code shall include references to the corresponding provisions of any future Internal Revenue Code, and references to any law, regulation, statute or ordinance shall likewise include references to the corresponding provisions of any future law, regulation, statute or ordinance.

11. *Amendment.* In addition to any requirements of the Nonstock Act, as the same may be revised from time to time, any modifications to Sections 3, 5(c), 9 or 11 of this Certificate of Incorporation must receive prior written approval by the Attorney General, and if necessary, additional approval by the Superior Court.

12. *Registered Office and Registered Agent.* The name of the registered agent of the Foundation is _____ whose office address is_____and whose residence address is _____.

13. *Incorporator.* The name and address of the sole incorporator of the corporation is _____, _____, _____.

Signed at_____, Connecticut this ___ day of _____, 201__.

_____

Incorporator

EXHIBIT Q10-2: INDEPENDENT FOUNDATION BYLAWS (DRAFT)

BYLAWS
OF
[NAME OF POST-CONVERSION FOUNDATION]

ARTICLE I
Name, Governing Law, Offices

The name of the corporation is "[Name of Post-Conversion Foundation]" (the "Foundation"). The Foundation shall be governed by the Connecticut Revised Nonstock Corporation Act, Chapter 602 of the Connecticut General Statutes (as the same may hereafter be revised or replaced, the "Nonstock Act"). The registered office of the Foundation shall be at such place in the State of Connecticut as the Board of Trustees of the Foundation (the "Board") shall from time to time designate.

ARTICLE II
Purpose

The purpose of the Foundation shall be as set forth in the Certificate of Incorporation and to provide for the healthcare needs of the greater Waterbury area, including the towns of Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown, Wolcott and Woodbury (the "Communities").

ARTICLE III
No Members

The Foundation shall have no members.

ARTICLE IV
Trustees

4.1 General; Qualifications. All corporate powers shall be exercised by or under the authority of, and the activities, property and affairs of the Foundation shall be managed by or under the direction of the Board. At least a majority of the Trustees shall live or work in the Communities. Consideration shall be given to a candidate's knowledge of the Communities, skill set, work experience, the diversity of the individual's cultural background ethnicity gender aged and socio economic status. No Trustee shall at the time of appointment or during the year prior to proposed service as a Trustee:

(a) be an employee or a member of the governing board of Greater Waterbury Health Network, Inc. or any of its affiliates (collectively, "GWHN");

(b) be an employee or a member of the governing board or community advisory board of the entity that purchases the assets of The Waterbury Hospital or an affiliate of such entity (collectively, the "Post Closing Hospital").

4.2 Number and Election of Trustees**. [include provisions for election of Trustees by Supported Organizations as necessary.]** There shall be not fewer than nine (9) or more than twelve (12) Trustees. The actual number of Trustees within such minimum and maximum shall initially be [_____] ([__]), and thereafter by prescribed resolution adopted from time to time by the Board. If no number is so prescribed by the Board, the number of Trustee positions shall be equal to the number of Trustees in office immediately after the most recent Annual Board Meeting (as defined in Section 4.4). The total number of Trustees shall be divided into three (3) classes, with each class consisting of one-third of the Trustees or as close to one-third as is practical. The terms of the Trustees shall be staggered so that the terms of one such class of Trustees shall expire at the Annual Board Meeting each year. At each Annual Board Meeting, Trustees shall be elected by the Board for a term of three (3) years to succeed the Trustees in the class whose terms expire at such Annual Board Meeting, except that Trustees may be elected to shorter terms as necessary to fill vacancies or to place or keep the staggered terms in effect. The Board shall be self-perpetuating to the extent that the Board elects the Trustees as set forth above.

4.3 Term Limits.

(a) Subject to Section 4.3(b), Trustees may serve a maximum of three (3) consecutive three-year terms in office, after which such person shall not be eligible to serve as a Trustee for a period of one (1) year. If a Trustee is elected to serve for a term of less than three (3) years, then such term shall not count as a term for purposes of computing term limits. For purposes of computing the time periods referred to in Section 4.2 and this Section 4.3, the full period between consecutive Annual Board Meetings shall be considered one (1) year.

(b) If a Trustee's term expires while the Trustee is serving as Chairman, Vice-Chairman or Secretary, then the Board shall re-elect such Trustee to serve an additional term as Trustee, even if such additional term would exceed the term limits provided in Section 4.3(a).

4.4 Annual Board Meeting. An annual meeting of the Board (the "Annual Board Meeting") for the election of Trustees and Officers, and other appropriate business, shall be held each year at a date, time and place designated by the Board. The Annual Board Meeting shall be considered one of the regular meetings of the Board.

4.5 Regular Meetings of the Board. In addition to the Annual Board Meeting, regular meetings of the Board shall be held at least four times each year in accordance with a schedule established for the year by the Board at each Annual Board Meeting, which may be revised thereafter at any duly called and convened meeting of the Board.

4.6 Special Meetings of the Board. Special meetings of the Board may be held at any time. Special meetings may be called by the President whenever he or she deems it appropriate, and shall be called by the Secretary at the request of any two (2) Trustees.

4.7 Method of Notice; when Notice is Effective; Contents of Notice. Not less than five (5) days' notice by mail, fax, telephone or e-mail shall be given to the Trustees of each regular meeting of the Board. Not less than seven (7) days' notice by mail, fax, telephone or e-

mail shall be given to the Trustees of each special meeting of the Board. Notice of the Annual Board Meeting and any other regular meeting of the Board shall state the date, time and place of the meeting and need not specify the business to be transacted at the meeting unless required by the Nonstock Act, the Certificate of Incorporation or a provision of the Bylaws, and notice of any special meeting of the Board shall state the date, time and place of the meeting and the business to be transacted at the meeting.

4.8 Place of Meetings. The Board may hold its meetings at such place or places within or without the State of Connecticut as the Board may from time to time determine.

4.9 Waiver of Notice. A Trustee may waive any notice required by the Nonstock Act, the Certificate of Incorporation or the Bylaws before or after the date and time stated in the notice. The waiver shall be in writing, signed by the Trustee entitled to the notice, and filed with the minutes or corporate records. Notwithstanding the foregoing, a Trustee's attendance at or participation in a meeting waives any required notice to the Trustee of the meeting unless the Trustee at the beginning of the meeting, or promptly upon the arrival of the Trustee, objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting.

4.10 Quorum. A quorum for the transaction of business at any meeting of the Board shall be a majority of the total number of Trustee positions prescribed at the time, including vacancies, if any.

4.11 Action by the Board. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, except as may otherwise be required by law or by the Certificate of Incorporation or the Bylaws. Each Trustee must act personally; there shall be no voting by proxy, power of attorney or other delegation method.

4.12 Action without Meeting. Any action required or permitted by the Nonstock Act to be taken at a Board meeting may be taken without a meeting if the action is taken by all Trustees. The action shall be evidenced by one (1) or more written consents describing the action taken, signed by each Trustee and included in the minutes or filed with the corporate records reflecting the action taken. Action taken under this section is effective when the last Trustee signs the consent, unless the consent specifies a different effective date. A consent signed under this section has the effect of a meeting vote and may be described as such in any document.

4.13 Telephonic, etc., Meeting. The Board may permit any or all Trustees to participate in a regular or special meeting by, or conduct the meeting through the use of, any means of communication, such as conference telephone communication, by which all Trustees participating may simultaneously hear each other during the meeting. A Trustee participating in a meeting by this means is deemed to be present in person at the meeting.

4.14 Resignation of Trustees. A Trustee may resign at any time by delivering written notice to the Board or the Foundation. A resignation is effective when the notice is delivered unless the notice specifies a later effective date.

4.15 Removal of Trustees. The Board may remove one or more of the Trustees with or without cause at any time by the affirmative vote of two-thirds (2/3) of the Trustees then in office. A Trustee may be removed by the Board only at a meeting called for the purpose of removing the Trustee and the meeting notice must state that the purpose, or one of the purposes, of the meeting is removal of the Trustee.

4.16 Vacancy among Trustees. If a vacancy occurs among the Trustees, including a vacancy resulting from an increase in the number of Trustees: (1) the Board may fill the vacancy; or (2) if the Trustees remaining in office constitute fewer than a quorum of the Board, they may fill the vacancy by the affirmative vote of a majority of all the Trustees remaining in office. The term of a Trustee elected between Annual Board Meetings to fill a vacancy expires at the next Annual Board Meeting. A vacancy that will occur at a specific later date, by reason of a resignation effective at a later date under Section 4.15 or otherwise, may be filled before the vacancy occurs but the new Trustee may not take office until the vacancy occurs.

ARTICLE V
Officers

5.1 General. The Officers of the Foundation shall be: a President, a Vice President, a Treasurer and a Secretary. The Officers of the Board shall be a Chairman and one or more Vice-Chairmen as the Board may prescribe. The Officers shall be elected by the Board at the Annual Board Meeting, or thereafter as the need may arise. Any two (2) or more such offices may be held by the same person. The duties of Officers shall be such as are prescribed by these Bylaws and as may be prescribed by the Board.

5.2 Terms of Office. The Chairman, Vice Chairman, Treasurer and Secretary shall each be elected from among the Trustees and serve for two (2) year terms and until his or her successor shall be duly elected, but any Officer may be removed by the Board at any time, with or without cause. The period between consecutive Annual Board Meetings shall be deemed one (1) year for this purpose. Vacancies among the Officers shall be filled by the Board. Other than the President and Vice-President, an Officer may serve a maximum of two (2) consecutive biannual terms in a given office. Thereafter, such person shall be ineligible to serve in the capacity as that Officer for a period of two (2) years. No Trustee shall be elected as an Officer who has exceeded his or her term limits as Trustee but continues to serve as Trustee as a result of the provisions of Section 4.3(b).

5.3 Chairman. The Chairman shall exercise overall supervision of Board affairs; preside at all meetings of the Board; provide leadership to the Board in formulating, developing and evaluating the policies and goals of the Foundation; represent the Foundation to the community and promote its interests; and appoint the members and chairmen of committees and Advisory Council, as necessary, in consultation with and upon approval of the Board. The Chairman shall also perform such other duties as may be assigned to him or her from time to time by the Board. The Chairman shall be elected from among the Trustees and may not serve as Chairman during any time that he or she is not a Trustee. The Chairman shall be an *ex-officio* member of all committees and shall be counted in determining a quorum and entitled to vote.

5.4 Vice-Chairmen. The Vice-Chairmen shall assist the Chairman in the exercise of his or her duties, and shall perform such other duties as may be assigned to him or her from time to time by the Board. Vice-Chairmen, if any, shall be elected from among the Trustees and may not serve as Vice-Chairmen during any time that he or she is not a Trustee.

5.5 President. The President shall be the Chief Executive Officer of the Foundation, and shall also perform such other duties as shall be assigned to him or her by the Board from time to time. The President may but need not be elected from among the Trustees at the time of election.

5.6 Vice President. Subject to any restrictions imposed by the Board, the Vice President shall perform the duties and have the powers of the President during the absence or disability of the President. The Vice President shall also perform such other duties as may be assigned to him or her by the Board from time to time. The Vice President may but need not be elected from among the Trustees at the time of such election.

5.7 Secretary. The Secretary shall be responsible for preparing and keeping a record of the proceedings of all meetings of the Board and for authenticating records of the Foundation. The Secretary shall issue all notices required by law or by these Bylaws. The Secretary shall have the custody of the seal of the Foundation and all books, records and papers of the Foundation, except as shall be in the charge of the Treasurer or of some other person authorized to have custody and possession thereof by a resolution of the Board, and shall discharge all other duties required of such officer by law or assigned to him or her from time to time by the Board or as are incident to the office of Secretary. The Secretary shall be elected from among the Trustees.

5.8 Treasurer. The Treasurer shall oversee the custody of all funds and securities of the Foundation, shall supervise the keeping of full and accurate accounts of receipts and disbursements of all funds of the Foundation, shall oversee the maintenance of the accounting books and records of the Foundation, and shall supervise the deposit of all monies and valuable effects in the name and to the credit of the Foundation in depositories designated by the Board. The Treasurer shall prepare or cause to be prepared an annual budget for the Foundation and shall submit it to the Board prior to the beginning of each fiscal year of the Foundation. The Treasurer shall prepare or cause to be prepared annual financial statements for the Foundation in form and substance satisfactory to the Board and shall submit such financial statements to the Board prior to each Annual Board Meeting. The Treasurer shall report to the Board periodically on the financial condition of the Foundation in such detail as the Board may request from time to time, and shall discharge all other duties required of such officer by law or assigned to him or her from time to time by the Board or as are incident to the office of Treasurer. The Treasurer shall be elected from among the Trustees.

ARTICLE VI
Committees

6.1 Composition of Committees.

(a) The Board may create committees, which may exercise the power and authority of the Board; provided, however, that each such committee must be composed entirely of two or more persons who are Trustees while they serve on such committee, and each such committee must be created, and shall have and may exercise such power and authority of the Board as shall be specified for it by vote of the greater of: (i) Trustees constituting a majority of the entire number of Directors in office at the time; or (ii) the number of Trustees required to take action under the Bylaws or the Certificate of Incorporation if either such document requires a vote greater than a majority of the entire number of Trustee in office at the time. A committee which is so created and appointed by the Board shall be referred to as a "Committee of the Board".

(b) Notwithstanding the foregoing, Committees of the Board may not: (i) fill vacancies on the Board or any of its committees; (ii) amend the Certificate of Incorporation; (iii) adopt, amend or repeal Bylaws; (iv) approve a plan of merger; (v) approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation, other than a mortgage, pledge or other encumbrance described in subdivision (2) of subsection (a) of section 33-1165 of the Nonstock Act; or (vi) approve a proposal to dissolve.

6.2 Additional Committees.

(a) In addition to Committees of the Board, the Corporation may have standing committees and such other committees as may be created by resolution of the Board. The standing committees and other committees may consist of Trustees, or of both Trustees and non-Trustees, provided that these shall be at least two Trustees appointed to each committee. Members of all committees shall be appointed annually by the Chairman and approved by the Board. The Chairman shall designate a Chairman and Vice-Chairman of each committee. Committee Chairmen, and in their absence the Committee Vice-Chairmen, shall conduct all committee meetings.

(b) No committee other than a Committee of the Board shall have or exercise any power or authority of the Board. A committee which is not a Committee of the Board may advise, recommend, investigate and report to the Board and/or to the officers of the Corporation on such matters as may be assigned to it, but shall not exercise the power or authority of the Board.

6.3 Standing Committees. The standing committees of the Foundation shall be the Governance and Nominating Committee, the Investment Committee, the Development Committee and the Audit Committee. Where these Bylaws prescribe a minimum number of Trustees to be appointed to a standing committee, the Chairman, as an *ex-officio* member of all committees, shall not be counted for the purpose of meeting such requirement.

6.4 Governance and Nominating Committee. There shall be a Governance and Nominating Committee consisting of no greater than **[eight (8)]** and not less than [three (3)] individuals chosen from among the Board and the Advisory Council and past Chairmen of the Foundation. Consideration for membership on the Committee shall be given to past Chairmen of the Foundation. The Governance and Nominating Committee will meet on an as needed basis at the direction of the Chairman, but will meet at least three (3) times per year, to include planning meetings in March and June, and one or two meetings in the fall, in order to make its nominations available to the Board by its regular meeting in **[May]**. The Governance and Nominating Committee is responsible for making recommendations to the Board on issues related to the size, structure, duties and effectiveness of the Board, making nominations to the Board and Advisory Council, and such other duties as may be provided in the Nomination Committee Charter approved by the Board from time to time and as otherwise assigned from time to time by the Chairman or the Board.

6.5 Investment Committee. There shall be an Investment Committee consisting of no less than five (5) members. The Investment Committee shall oversee investable funds of the Foundation and shall be charged with the supervision of the investment advisors so engaged by Foundation to manage and invest such funds under the investment guidelines and objectives which have been ratified by the Board. The Investment Committee shall also be charged with examining and recommending options for the handling of the Foundation's terminated pension plan. The Committee shall meet on a quarterly basis and report its activities to the full Board at its next regularly scheduled meeting. The Investment Committee's responsibilities shall also include those set forth on the Investment Committee Charter approved by the Board from time to time. Any changes to the Investment Committee Charter shall require approval of the Board.

6.6 Development Committee. There shall be a Development Committee of no less than **[three (3)]** members. The Development Committee shall oversee matters related to charitable resource development of the Foundation. The Development Committee's responsibilities shall also include those set forth on the Development Committee Charter approved by the Board from time to time. Any changes to the Development Committee Charter shall require approval of the Board.

6.7 Audit Committee. There shall be an Audit Committee consisting of **[three (3)]** members. **[Two (2)]** individuals shall be Trustees; all members of the Audit Committee shall have sufficient financial literacy to carry at the duties of the Audit Committee and shall be independent of the management of the Foundation, its affiliates, subsidiaries and the Post Closing Hospital and free of any relationship that in the opinion of the Board would interfere with their judgment as a committee member. Two members of this Audit Committee shall constitute a quorum, and the vote of the majority of members present shall be the act of the Audit Committee.

(a) The Audit Committee shall meet a minimum of three (3) times each year, and at the call of its chairman or the President. Audit Committee meetings may also be called by any two (2) members of the Audit Committee.

(b) The Audit Committee shall make or cause to be made such examinations of the financial affairs of the Foundation and its affiliates and subsidiaries (other than the Post

Closing Hospital) as shall be sufficient, in the opinion of the Audit Committee, to determine whether the financial condition of the Foundation and its affiliates and subsidiaries (other than the Post Closing Hospital) is sound, their practices correct, and the financial information furnished by their respective officers correct and compliant with applicable reporting requirements. The Audit Committee shall study each report on the Foundation conducted by the outside auditors, if any, and may consult directly with such auditors. The Audit Committee annually shall recommend to the Board an independent audit firm for the Foundation.

(c) The Audit Committee shall keep minutes of its meetings, and such minutes shall be submitted at the next regular meeting of the Board and any action taken by the Board with respect thereto shall be entered in the minutes of the Board.

(d) The Audit Committee's responsibilities shall also include those set forth on the Audit Committee Charter approved by the Board from time to time. Any changes to the Audit Committee Charter shall require approval of the Board.

(e) The Audit Committee shall develop, monitor and make recommendations to the Board with respect to financial reporting and compliance for the Foundation, including an appropriate educational component and audit procedures so that Trustees, senior management and staff of the Foundation are familiar with financial reporting and compliance.

ARTICLE VII
Miscellaneous

7.1 Seal. The seal of the Foundation shall be in such form as may be adopted by the Board.

7.2 Fiscal Year. The fiscal year of the Foundation shall end on September 30 of each year.

7.3 Conflict of Interest Policy. The Board shall adopt from time to time a conflict of interest policy.

ARTICLE VIII
Amendments

These Bylaws may be altered, amended or repealed at a meeting of the Board by the affirmative vote of two-thirds (2/3) if the notice for the meeting gave notice of and included the text of the proposed change; provided, however, that no amendment shall be effective that changes a quorum or voting requirement shall require such greater vote as may be required by the Nonstock Act.

EXHIBIT Q11-1: CHARITABLE GIFT ANALYSIS

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Not Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Charles F. Brooker Will and Codicil		$179,256	"in trust for the following purposes to wit: To be invested in the manner prescribed by law for trust funds, said fund to be known as the "CHARLES F. BROOKER FUND" and held in trust as a permanent fund, and the income therefrom to be used for the expenses and carrying on of the purposes of said Hospital. "I request said WATERBURY HOSPITAL of Waterbury in their respective use of the income from the aforesaid trust funds to give the preference to employees of the American Brass Company and its successors …	None	Y	N	N	N	Will being sent by Derby Probate Court
Clara A. Forester (Richard A. Forester Memorial Fund) 5/15/1956		$85,277	"the principal to be held by it in a perpetual trust to be known as 'The Richard A. Forester Memorial Fund' and the income only thereof to be used for the general purposes of said organization."	None	Y	N	N	N	Yes Trust u/w
Karl & Margaret Hallden Memorial Fund 7/25/1967	Bank of America, Agent	$101,083	principal distributed from Memorial Fund 6/1/1986 – consent to distribution in file	None	Y	N	N	N	Yes Will, Consent to Distribution and 12/20/85 letter from Colonial Bank detailing provisions of gift, Agreement between Waterbury Hospital and Colonial Bank

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Not Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
George R. Lamb (George B. Lamb and Harriet Welton Lamb Endowment Fund) 7/12/1923		$292,587	"the principal of said fund to be kept intact . . . and only the income therefrom used as the Board of Directors may determine for promoting and maintaining the Hospital and its work" "income therefrom used as the Board of Trustees may determine for promoting and maintaining the Hospital and its work"	"If for any reason said Waterbury Hospital shall fail or refuse to accept said fund upon the conditions above stated, the Trustee shall . . . set over all of the . . . assets belonging to the Trust Fund to such person . . . as shall have been designated by me in my last will and testament . . . ."	Y	N	N	N	Extract from Trust and Trust Agreement between Waterbury Hospital and Colonial Bank Trustee dated 1967

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Hattie/Harriet Schlegel Anderson May, 1986 July 21, 1986		$122,672	"income therefrom to be used to provide for the ongoing education of nurses at the Hospital through in-service programs, outside speakers, conference fees and expenses, tuition assistance in obtaining advanced degrees, or for other employees to become Registered Nurses, and books periodicals and other educational support systems"	None	Y	N	Y	N	Proposed language re distribution, and Custodial Agreement
At Risk Kids 1999		$1,040	Income will be used to "underwrite operations, after grant income has been exhausted, for programs that focus on preventive strategies designed to decrease serious emotional and behavioral problems."	None	Y	N	Y	Y	Yes Resolution
Theodore Bevans 10/16/1963		$8,759	"used for the benefit of children hospitalized in the Waterbury Hospital."	None	N	Y	Y	N	Yes Contribution letter
Edith M. Chase (Henry Sabin Chase Memorial Fund) 1/24/1972	The Waterbury Hospital	$813,117	"to establish and maintain a dispensary under the name, 'The Henry Sabin Chase Memorial Dispensary."	None	Y	N	Y	N	Yes Will
Mildred Crozier 12/28/1988	The Waterbury Hospital	$289,435	"the income of the Fund, and such amount of the net appreciation (realized and unrealized) thereof…be used…to provide scholarship assistance to children of Hospital employees so as to enable them to pursue their professional education in medicine and related fields of caring." "…it is my desire that no part of the value of any contribution made by me…be so expended"	None	Y	N	Y	Y	Yes Instrument of Gift

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Marguerite B. Fulling 3/21/66 6/19/96		$78,961	"to be known as the Marguerite B. Fulling Research Fund, only the income from which is to be used for research of breast cancer".	Unknown – trust document not located	Y	N	Y	N	Gift letter and Waterbury Hospital Receipt & Release
Grad Nurse 1/30/1979		$7,359	To provide loans to graduate nurses for further education	None	Y	N	Y	Y	Yes Memorandum
Junior League Fund 2/1937 (memo from The Colonial Trust Co.)	The Waterbury Hospital	$2,199	"condition of gift: To be used as a special Medical Fund." – memo from The Colonial Trust Company "Amount of Gift - $1,500.00"	None	Y	N	Y	N	Yes Instrument of Gift
Sarann B. Kazanjian (Sarann B. Kazanjian Memorial Fund) 10/17/1974	The Waterbury Hospital	$72,495	"Fifty Thousand Dollars ($50,000.00) to The Waterbury Hospital,…and that the income from it be used to purchase equipment for medical and surgical purposes." ——— "If any of the principal or net income of the Residuary Trust shall remain undisposed of after compliance with all of the foregoing provisions of this Article VI, I direct my then Trustees to pay, transfer and deliver said undistributed portion to The Waterbury Hospital, to be to it absolutely."	None ——— None	Y ——— N	N ——— Y	Y ——— N	N ——— N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Sarann B. Kazanjian (Sarann B. Kazanjian Student Nurse Scholarship Fund) 8/12/1955 (citation to letter in unknown memo)	The Waterbury Hospital	$49,544	"$10,000.00 payable to the Waterbury Hospital… and the annual income therefrom be used to defray expenses of a student nurse or nurses during her or their period of nursing training. She further requests that preference be given to those student nurses residing in Waterbury and the surrounding towns of Naugatuck, Woodbury, Middlebury and Watertown…"	None	Y	N	Y	N	Yes Instrument of Gift – Student Nurse Scholarship Fund
LJ Mayo		$13,394	Scholarships for nursing students Gift in memory of Lewis Mayo, former pharmacist at Waterbury Hospital	None	N	Y	Y	Y	Yes Hospital Summary
Dr. M.H. Merriman 9/22/1964		$5,488	"to be established as a fund, the income of which is to be used to defray the expenses of personnel in the Waterbury Hospital Clinical and Pathological Laboratories in attending scientific meetings."	None	Y	N	Y	Y	Yes Draft Memorandum

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non- Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
Harriet/Hattie S. Anderson 9/21/1943	Bank of America	$89,126	"income to be used by said Waterbury Hospital Corporation to provide or assist in providing hospital care to deserving and needy residents of the City of Waterbury, Connecticut."	None	N	Y	Y	N	Yes Instrument of Gift
Mary Kingsbury Bull Fund (established by Edith Kingsbury) 1/24/1951	Bank of America	$22,988	"for the furnishing and providing an endowment of the Children's Ward in The Waterbury Hospital. When the furnishing is completed enough of the bonds are to be sold for payment to the Hospital and the balance to be carried in separate account with int. accruing against future withdrawal for replenishment."	None	N	Y	Y	N	Yes Record of Gift/Trust Agreement with Hospital
Almon B. Dayton 8/23/1940	Bank of America	$113,372 which is 6.67% of the total	"one-fifth of the net annual income of said trust shall be paid … annually in equal shares unto The Waterbury Hospital …, The Waterbury Anti-Tuberculosis League of Waterbury, Incorporated… and The Gaylord Farm Sanatorium…, in perpetuity."	"If any one or more of aforesaid religious and philanthropic organizations named as beneficiaries herein shall cease to exist or shall relinquish its corporate charter, or shall fail for any reason to function in the territory in which it is now located, its share of the income as hereinbefore determined shall be paid by my said trustee to The Waterbury Foundation Incorporated of Waterbury, Connecticut, to be used by the directors of said Foundation for religious or charitable purposes, preferably for some use similar to that performed by the corporation previously receiving said income."	N	Y	N	N	Yes Trust u/w
Natalie M. Dodd f/b/o Paul Heroux 5/18/76 9/13/84	J.P. Morgan & Co.	$0	"the balance of the remaining principal of the trust as follows: … 15% thereof to The Waterbury Hospital"	"In the event that an organization to which a portion or all of the remaining principal of the trust is directed to be paid…shall not be an exempt organization at the time of the Settlor's death, such portion…of the remaining principal of the trust shall	N	Y	N	N	Yes Amended and Restated Agreement and Will

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Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
				be paid, in the same proportions as aforementioned, to such of the aforementioned organizations as shall then be in existence and exempt organizations, or, if none of the aforementioned organizations shall then be in existence and an exempt organization, the same shall be paid only to such exempt organization or exempt organizations…as the Trustee, in its absolute discretion, shall determine."					
John Elton #2 for St. John's Parish 11/29/46 6/26/1947	Bank of America	$308,695 which is 50% of total	"net income. . . in equal shares, to St. John's Parish of the Protestant Episcopal Church . . . and to The Waterbury Hospital . . . to be to each of them absolutely."	None	N	Y	N	N	Yes Will and Codicil
J. Lincoln Fenn 10/23/1950	Stanhope Fenn Cunningham	$0	1 of 5 contingent remaindermen – Petition to Superior Court of California for transfer of trust to California was granted.	"…. To the Waterbury Hospital of Waterbury, Connecticut. I request that the shares of property that may be received by the above named institutions shall be added to their principal funds and kept safely, invested, and that only the income be used for the general purposes of said institutions respectively."	N	Y	N	N	Yes Trust u/w
I. Kent Fulton 10/02/1939 and 12/15/1939	Bank of America	$6,841,675	"To my trustee … I give and bequeath the sum of Twenty-five Thousand Dollars ($25,000), to be held by it in trust and the net income thereof to be paid over annually to the Waterbury Hospital… to be used by said Hospital for its general uses and purposes."	None	N	Y	N	N	Yes Trust u/w and Codicil
Donald F. Gibson 9/24/1983	JPMorgan Chase	$0	remainder beneficiary- approximate value $30,000	None	N	Y	N	N	Yes Trust u/w

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Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
Charles Hellmann (Sibilla Hellmann Fund) 6/13/1955	Bank of America	$10,428,750 which is 50% of total	"yearly income shall be divided equally between The Waterbury Hospital, Inc. and The St. Mary's Hospital Corporation . . . income to be used by each hospital as it may deem for the best interests of each hospital."	"In the event that either hospital goes out of existence, the entire net income shall be paid to the remaining hospital. If either hospital shall merge with another hospital and my Trustees believe that the corporation so formed carries out the purposes of the hospital so merged, then my Trustees shall pay one-half of the income to such amalgamated corporation, but, if my Trustees believe that the amalgamated corporation does not carry out the purposes of the hospital so merged and mentioned herein, then the entire income shall be paid to the remaining hospital. Should both hospitals mentioned herein cease to exist and there shall be no corporation or corporations formed as aforesaid so that there will be no charitable or eleemosynary corporation or corporations to which the income from the trust shall be paid, then my Trustees shall give the net income to the Meriden hospital, and, in the event that said hospital has ceased to exist or has not been amalgamated with any other charitable institution carrying out the ideals and principals of such institution, then my Trustees shall pay the net income in such proportion as they may deem advisable to other charitable, religious and eleemosynary corporations as shall be located in said Waterbury which carry out the principles and teachings of The Waterbury Hospital Inc. and The St. Mary's hospital corporation, and my Trustees shall have full discretion to designate the appropriate corporation or corporations and shall have full discretion as to the proportion of the net income which shall be paid to each corporation designated."	N	Y	N	N	Yes Trust u/w
Rhoda M. Hellman (Sibilla Hellman Fund) 11/11/1969	Bank of America	$5,369,352 which is 50% of total	"During the continuation of this trust the net income arising therefrom shall be divided equally between the Waterbury Hospital and St. Mary's Hospital, such payments to be made quarter-yearly or at such more frequent intervals as the Trustee shall deem wise."	"If either of the hospitals listed above is not an organization described in Sections 170(a), 2055(a) and 2522(a) of the Internal Revenue Code or has ceased to exist when income of the trust is to be distributed to it, the Trustee shall distribute all such income to the remaining hospital. If neither hospital shall qualify under such sections the Trustee shall distribute the income to such other organizations in the health care	N	Y	N	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
				field as are described in said Sections 1770(c), 2055(a) and 2522(a) as the Trustees shall select."					
Frank Keeling (The Frank Keeling Fund) 12/15/1954	Bank of America	$3,314,155	"income only thereof to be paid . . . to be used for the general purposes of said Hospital"	None	N	Y	N	N	Yes Trust u/w
Jacob Keeling (The Jacob Keeling Fund) 6/30/1952	Bank of America	$2,554,825	"income only thereof to be paid . . . to be used for the general purposes of said Hospital"	None	N	Y	N	N	Yes Trust u/w

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non- Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
Harriet Kirk 6/15/1942	JP Morgan Chase	$437,028 which is 20% of total	"one-tenth of the net income to The Waterbury Hospital, Inc., … the same to be used for the general purposes of the corporation."	"In the event that said corporation goes out of existence, then said income shall be divided equally among the other corporations and associations mentioned in Section B; but, if said corporation shall merge with any other corporation and my Trustee believes that the corporation so formed carries out the purposes of THE WATERBURY HOSPITAL, INC., then my Trustee shall pay the net income to such amalgamated corporation, but, if my Trustee believes that the amalgamated corporation does not carry out the purposes of THE WATERBURY HOSPITAL, INC., then the net income shall be divided equally among the other charitable and eleemosynary corporations and association mentioned in Section B. … Should all of the corporations mentioned in Sections A and B aforesaid cease to exist,… then my Trustee shall give the net income, in such proportion as it may deem advisable, to other charitable, religious and eleemosynary corporations as shall be located in Waterbury, which carry out the principles and teachings of the corporations hereinbefore mentioned…" Note: The corporations and association mentioned in Section B are Waterbury Day Nursery Association, The Southmayd Home, Inc., The Waterbury Visiting Nurses' Association, Inc. and The St. Mary's Hospital Corporation.	N	Y	N	N	Yes Trust u/w
Henry H. Peck 6/12/1918	Bank of America	$8,444,443	"Whereas, the Board of Directors of the Waterbury Hospital…has entered into a contract for the construction of an addition to the buildings of said hospital,…I direct my executor to pay over to the Treasurer of said Hospital such sum as may be determined by my executor and the Board of Directors of said Hospital to be necessary to pay the cost of said building.	None	N	Y	N	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
			... "pay over the net income semi-annually to the Waterbury Hospital...for general uses of said institution.						
Edith F. Poole 4/11/1928 (Francis A. and Florence A. Poole Fund)	Bank of America	$145,712 (50% of total)	"the net income thereof shall be divided equally, semi-annually, between the Second Congregational Church . . . and the Waterbury Hospital . . . the same to be used for the general purposes of said organizations."	None	N	Y	N	N	Yes Will
Wilma A. Snowden 10/25/1984 12/27/1990	Comerica Bank	$0	Contingent remainder interest	None	N	Y	N	N	Yes, Trust Agreement and Amendment
Kenneth J. Stoughton for Paul L. Baraby 6/13/1977	Bank of America	$0	"Upon the death of said Paul L. Baraby, the entire corpus of said Trust shall be distributed to The Waterbury Hospital...to be added to its equipment fund... 12/31 Value - $360,700	None	N	Y	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule C. Miscellaneous

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Gift Annuity April 3, 2003	Waterbury Hospital	$138,540	Gift annuity funds payable to Waterbury Hospital at donor's death	None	N	Y	N	Y	Board Resolution, Letter of Understanding and Investment Policy Statement
Molly Patricia Lenners 2/27/08 PENDING: Temporary Administrator appointed 10/16/14		Estimate $500,000	The remainder of my estate, or all of my residuary estate if Douglas L. Fox does not survive me, shall be distributed as follows: 1. One third to St. Mary's Hospital of Waterbury, Connecticut to be used for the care and treatment of mental illness; and 2. Two thirds to Waterbury Hospital of Waterbury, Connecticut		N	Y	N		Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Permanent Bed Fund Various Dates	Waterbury Hospital Trustee, Bank of America, Agent	$5,260,455	See Bed Fund documentation	See Bed Fund documentation	Y	N	Y	N	
Edith Blakesley Fund 03/08/1961	JPMorgan Chase $2,328,423.42 As of 9/30/15	$0	"net income to be used by Hospital as a free bed fund for members of the Second Congregational Church who are considered as worthy ill cases requiring financial assistance". Also used by other churches and for payments at St. Mary's Hospital	"In the event that said The Waterbury Hospital shall be merged into or taken over by another private nonprofit hospital the said Trustee shall make payment to the successor corporation. In the event that the said The Waterbury Hospital shall terminate its existence, the said Trustee shall have the power to send such income to such hospital operating in the City of Waterbury, or serving the public of the City of Waterbury, as it may, in its judgment , select."	N	Y	Y	N	Yes Trust u/w
Margery K. Hayden (Elizabeth K. Hayden Fund) 02/03/1975	The Waterbury Hospital	$35,368	"the sum of Twenty Thousand Dollars ($20,000) to be known as "The Elizabeth K. Hayden Fund", to establish a bed fund, the income from which shall be used for the purpose of providing free bed and medical care to patients of Southmayd Home, Incorporated, of said Waterbury, who shall be designated by the Board of Directors of said Southmayd Home, Incorporated, as being eligible to receive said free bed and medical care. In the event that all or any portion of said income in any consecutive twelve months period (said period to be determined by said Hospital, in its sole discretion) shall not be needed for the purpose of providing free bed and medical care, same may be used by said Hospital for its general purposes."	None	Y	N	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Merrit Heminway (Merrit Heminway Bed Fund) 1914 (extract from executive committee report)	Waterbury Hospital	$248,106	From Hospital Records: "Income to maintain bed for Watertown poor." Letter 10/31/60 from Katherine H. Heminway: "wish of his family that the income from this sum be added to that of the Merritt Heminway Bed Fund and administered as that fund has been administered in the past . . . . We wish that the word "poor" be interpreted to mean anyone whose hospital bills (not being otherwise fully covered) are such that the patient would be burdened thereby so that help in their payment might be considered of curative value. It is also our wish that any income from this fund left at the end of each hospital fiscal year be turned over to the hospital's general funds."	"The Board of the hospital should feel free to request the family of Merrit Heminway to change the above provisos if in their opinion the fund is no longer serving a useful purpose. If the time should arise when there were no family left to confer with, the interest and principal of the fund should be used in such a way as best to serve Watertown patients."	Y	N	Y	N	Instrument of Gift – Addition to Bed Fund

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Abbie C. Hopkins 4/30/1938	Bank of America	$5,939,804	"If, however, at the termination of said twenty-year period, no hospital has been built by the Naugatuck Hospital in said Naugatuck, I direct the Trustee to continue to hold and invest and reinvest said fund and the increment thereto, as aforesaid, until a hospital has been erected in said Naugatuck by the Naugatuck Hospital, and meantime to pay to The Waterbury Hospital…said remainder of the net income from said fund and from the increment thereto for the purpose of providing accommodations and medical care and attention for the poor and needy residents of the Borough of Naugatuck aforesaid, with the understanding, however, that the surplus of said income, if any, may be used by The Waterbury Hospital aforesaid for its general uses and purposes. (c) If, at some later period, a hospital is erected in said Naugatuck by the Naugatuck Hospital, I direct the Trustee to pay said remainder of the net income from said fund and from the increment thereto, in perpetuity, to the Naugatuck Hospital, to be used for the general purposes of said institution."	None	N	Y	Y	N	Yes Will
Mary L. Meigs (The Meigs Fund) 7/17/1952	The Waterbury Hospital	$1,243,892	"... the principal thereof to be held as a perpetual trust to be known as the "Meigs Fund", and the income only thereof to be used for the care at said hospital of persons in reduced circumstances in such manner as the Board of Directors of said Hospital may determine"	None	Y	N	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Edith F. Poole 4/11/1928 (Francis A. and Florence A. Poole Fund)	Waterbury Hospital	Part of Permanent Bed Fund	"($10,000), to the Waterbury Hospital…to be held as a permanent fund and invested and reinvested, and the net income thereof applied towards the establishment and maintenance of a free room in said hospital for the use of such person or persons as the minister in charge for the time being, of the Second Congregational Church, of Waterbury, Connecticut, may designate.	None	Y	N	Y	N	Yes Will
Scovill-Kingsbury Bed Fund 1915 (extract from Executive Committee Report)	Waterbury Hospital	$252,036	"extract from Report of Executive Committee 1915: 'endowing a free cot for the benefit of the poor of St. John's parish Waterbury'." - undated Waterbury Hospital record	None	Y	N	Y	N	Yes Acknowledgment of $5,000 gift by hospital
Flora S. Page and George W. Smith (Curtis Hurlbut Smith Bed Fund)	Waterbury Hospital	$199,434	"The Curtis Hurlbut Smith Endowed Bed has been added to our list. Mr. Smith, a native of Southbury, is thus memorialized by the generosity of a brother and sister."	None	Y	N	Y	N	Yes Hospital Summary

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
W. Easton Smith 5/31/44 (Howard Easton Smith Fund)	Bank of America	$129,635	"I give and bequeath to The Colonial Trust Company, of Waterbury, Connecticut, the sum of Five Thousand Dollars ($5,000.00), in trust, however, to hold, manage, invest and reinvest, and pay over the net income thereof semi-annually to the Waterbury Day Nursery Association, of said Waterbury, for its general purposes, said fund to be known as "The Howard Easton Smith Fund." "Should any of the corporations, institutions or organizations named as beneficiaries of the trust created by Paragraphs 8, 9 and 10 of this Will, dissolve, terminate or cease to carry on their corporate purposes, I direct that the income otherwise to be paid to such corporation, institution or organization shall thereafter be paid to The Waterbury Hospital, of said Waterbury, for its general purposes."	None	N	Y	N	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Ruth Sperry (Mr. and Mrs. Mark L. Sperry, Sr. Memorial Fund) Letter 12/3/1947 Letter 7/13/1976	The Waterbury Hospital	$197,525	"$2,500. to be used toward a hospital Bed Fund. .. 1. For employees and their families of the Scovill Mfg. Co. 2. For members of the Sperry family. 3. For such persons as I, or somebody that I might designate, might direct. I wish the unexpended balance in the fund to be carried over to the next year until the Fund reaches the sum of $10,000. After that it may be turned over to the Superintendent for general purposes of the institution." ——— "I give to the Waterbury Hospital...approximately $10,000 to be added to the Mark L. Sperry and Julia P. Sperry Bed Fund. The income to be used preferably for members of The First Congregational Church and employees of The Scovill Manufacturing Company or to anyone in need of hospital assistance."	None	Y ——— Y	N ——— N	Y ——— Y	N ——— N	See Bed Fund Binder
Dwight H. Terry And Martha Terry (The Dwight H. and Martha J. Terry Fund) 3/08/1919 11/21/1918	The Waterbury Hospital	$689,169	"only the proceeds thereof shall be used for the purpose of providing free beds and medical care and attention for the poor and needy of the Towns of Plymouth and Thomaston . . . and that the surplus of said income, if any, may be used for the general uses of said institution"	None	Y	N	Y	N	Yes Trust u/w Dwight Terry and Trust u/w Martha Terry
Olive Rogers Warner (The Richard Vincent Warner Memorial Fund) 4/22/1926	The Waterbury Hospital	$1,433,242	"as a trust fund . . . . only the proceeds thereof shall be used for the purpose of providing accommodations and medical care and attention for the residents of the Borough of Naugatuck . . . and that the surplus of said income, if any, may be used for the general uses of said institution"	None	Y	N	N	N	Yes Will

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Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Estate of Oscar L. Warner (The Warner Memorial Fund) 2/29/1932	Bank of America	$2,476,144	"the income thereof for the purposes of providing accommodations and medical care and attention for the poor and needy residents of the Borough of Naugatuck, Connecticut, with the understanding, however, that the surplus of such income, if any, may be used for the general purposes"	None	N	Y	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule E. General Endowment Fund / Not True Endowment / Board Designated

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
General Endowment Fund	Waterbury Hospital	$1,914,232	Consists solely of outright gifts		N	Y	N	Y	

EXHIBIT Q11-2: CHARITABLE GIFT INSTRUMENTS (CD)

EXHIBIT Q12-1

ADDITIONAL OFFERS RECEIVED BY HOSPITAL

Allied Global Consulting Inc.

AGC

Dated 04/27/15

To
Mr. James Cain
The Cain Brothers.
360 Madison Avenue, 5th Floor
New York, NY 10017

Subject: Proposal to bid for Greater Waterbury Health Network .

Jim Hi,

Allied Global Consulting INC / Allied Assets INC is pleased to propose Joint Venture between GWHN - 20% and Allied Global Consulting 80%. 80% ownership of $35,000,000.00 which would be paid for by allied global consulting group with 80% ownership of GWHN asset and revenue base. In addition Allied Global consulting will Invest 80% of 55 Million for the capital improvements of the GWHN over next 7 Years. Allied Global Consulting INC / Allied Assets INC, was able to secure 100% funding of the proposed bid amount through M&T Bank.

Allied Global Consulting will be aligned with Quorom Health Resources to run the operations of the GWHN. Allied Global Consulting will be going under a minimum of 24 months to 48 months agreement to run the GWHN. The agreement between Allied Global Consulting and QHR will be finalized upon the completion of the joint venture deal.

Should you have any questions, please feel free to contact me. (Cell 714-875-1521)

Sincerely.

Syed Kazmi
Managing Director

(Electronic Signature)
Signed and Dated 07/14/14

EXHIBIT Q14-1

TRANSCRIPT OF INFORMAL HEARING REQUIRED BY CONN. GEN. STAT. §19a-486a(c)

PUBLIC HEARING

APPLICANTS
Greater Waterbury Health Network, Inc.
Prospect Medical Holdings, Inc.

TOWN
Waterbury, Connecticut

PROPOSAL
Proposed Transfer of Assets of Greater Waterbury Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

DATE AND TIME
Wednesday, August 5, 2015 at 5:00 p.m.

PLACE
Courtyard by Marriott
63 Grand Street
Waterbury, Connecticut

BRANDON HUSEBY REPORTING & VIDEO
249 Pearl Street
Hartford, CT 06103
(860) 549-1850
(800) 852-4589
Reporter: Tiffany V. Pratt, LSR #00128

(Hearing commenced: 05:05 p.m.)

MR. CONTADINI: Welcome. I'd like to first off say my name is Carl Contadini. I'm Chairman of the Board of Greater Waterbury Health Network, and the goal of this evening's hearing is to provide our community with an overview of the transaction between Greater Waterbury Health Network, the parent organization of Waterbury Hospital, and Prospect Medical Holdings. This opportunity is to offer members of our community an opportunity to ask questions, offer comments in regards to the transaction that goes through the regulatory process.

The agenda for this evening is that following me will be Darlene Stromstad, President/CEO of Greater Waterbury Health Network, will provide an overview of Greater Waterbury Health Network today and plans for future growth and partnership. Dr. Carl Sherter, member of the Greater Waterbury Health Network Transaction Task Force, will share the medical staff involvement in the process. Ann Zucker, Greater Waterbury Health Network attorney at Carmody, Torrance, Sandak & Hennessey will describe the statutory requirements

for the hearing and conversion process and discuss the structure in terms of the transaction, and then we will open the floor to comments and questions. Dr. Mitchell Lew, President of Prospect Medical Holdings, and Tom Reardon, President of Prospect East, are here with us this evening to also answer questions.

Tonight's presentation and the questions-and-answer period will be recorded, transcribed and submitted to the state Department of Public Health, the Office of Health Care Access and the Office of the Attorney General. This hearing is a legal requirement for the state regulatory approval process.

For the question-and-answer comment portion of this evening, you must sign in if you wish to comment or ask questions. If you do not sign in -- if you have not signed in and wish to speak, please go to the registration desk to do so. If you have signed in to testify, I will call your name to come up to one of the microphones to make your statement or ask questions. Before you begin your testimony, please state your name and the town of residence. In order to give everyone who wishes a chance to speak, we request that each speaker

limit their participation to one appearance at the microphone and limit your comments to no more than three minutes. Your statements or comments should be directed to the contents of the letter of determination.

Copies of the letter of determination are available this evening for your review. They're on the table outside the door. The letter of determination may also be found on the attorney general's website along with other filings for this regulatory approval process and will be available on site of the Office of Health Care Access website as the process advances.

Before we begin this evening's presentation, we've asked the mayor of this great city of Waterbury to say a few remarks. We welcome Mayor O'Leary.

MAYOR O'LEARY: Good evening everyone. Thank you Carl, Darlene. I am Neil O'Leary. I'm the mayor of the City of Waterbury. I'm here this evening to express my strong support for the proposed transaction between Waterbury Hospital, Greater Waterbury Health Network and Prospect Medical Holdings.

First, let me state the obvious. Here

we are once again discussing the future of the health care system in our region. I am confident that with this transaction we can finally move forward. The reason I say this is despite the disappointments of the recent past, I believe this is Waterbury Hospital and Greater Waterbury Health Network's moment. We will take the next step in building a world class health care system.

Tonight we will hear Waterbury Hospital and Prospect Medical Holdings, and most importantly we will hear from this community, but I hope to make a point to the regulators who will ultimately have to approve this transaction, when they review the transcript from this evening, I hope they will understand that these are far more than words that they are reviewing. These are lives, the lives of the residents of this region, the fundamental health care opportunities that all, including those who most desperately need access, can be assured of.

This transaction is about the future incredible professions in the Waterbury Hospital Network who dedicate themselves every day to us, our families, friends and neighbors. This is not only about the stability of their jobs, but the economic viability of this entire region.

Our city and region are on the cusp of resurgence. This application we speak of tonight is a vital building block in that resurgence, and I am entirely confident that this transaction is the right path for health care in Waterbury.

It is very clear that the health care environment is significantly and rapidly changing. There is no going back. The leadership of Waterbury Hospital and Greater Waterbury Health Network anticipated these major shifts in health care and have been working to establish a partnership with a strong capital partner to ensure the sustainability of health care services for our community.

For the last 125 years Waterbury Hospital has been growing and adapting to meet the community's dynamic health care needs, and I have no doubts whatsoever that they will continue to do so.

The hospital is a vital community asset. It provides health and medical care, of course, but it also conducts outreach and education in the community. It educates the future health care and medical workforce and its regional economic engine with 2,000 employees. It is clearly an essential resource and asset for the city in the greater Waterbury region.

I recently met with representatives of Prospect Medical Holdings to learn more about the company and the benefits it could bring to Waterbury Hospital, Greater Waterbury Health Network and this community. I was very, very pleased and very impressed with their innovative model and what they have been accomplishing in California, Texas, and Rhode Island. I know we will hear more about that in detail this evening, and I'm excited. It is what Waterbury and this entire region desperately needs. We deserve no less than a leading edge, world class health care system.

Yes, they will invest capital to update areas of Waterbury Hospital, but they will also be investing in expanding access to health care throughout this community that is bringing health care and resources to people where they live.

The overriding goal of Prospect's health care model is to improve the health of the community through more effective management and coordination of population health. This involves more than just the hospital, but the entire health care system and local community resources. This is the new era of health care, and Prospect has demonstrated with its regional coordinated care

model that it can both improve the community's health while controlling costs.

I'm excited by the opportunities, resources and expertise that Prospect brings to our region.

I am supporting the acquisition of the Greater Waterbury Health Network by Prospect Medical Holdings because it will strengthen health care services for our community both today and for generations to come.

You know, we have been down this road, as I mentioned earlier. When I was elected and started office in December 2011, I never expected to endure the peaks and valleys of this process starting with LHP and Tenet, but I am confident and I really am standing here in complete confidence having spent significant amount of time with Prospect and talking at length with Darlene and her staff that the people, the staff, the fine staff, committed staff at Waterbury Hospital really believe this is it. I'm also confident that the officials in Hartford believe this is it.

I'm a little scared, little anxious. Father, pray for me, please. But I really am excited. I had a great feeling after meeting

Tom Reardon the first few minutes and several conversations, and, you know, Kevin and I have done an incredible amount of research on Prospect, and I'm not a hospital administrator, nor am I a doctor, but I am the leader of a community that has been through too many peaks and valleys, and this is our time, and we need to send a message clearly to the state and for all those that are in this reviewing process that we're comfortable, and I believe we are comfortable. It's been a long, arduous road, but I truly believe from the bottom of my heart that we finally got -- that we're here. We just have to keep it going and get it done.

So I really do appreciate the opportunity to speak with you all here tonight. I've got this horrendous schedule, and I've got to get back to where I came from, but I just really felt that it was so important for me to be here with you tonight and let you know how we feel together, collaborating, working together for the right, and the right here is this acquisition. Thank you all.

MR. CONTADINI: Thank you, Mayor O'Leary.

To continue in our presentation this evening, what I would like to first do is to go over

the organizations that are included in the Greater Waterbury Health Network. In that network is Waterbury Hospital, VNA Health at Home, Greater Waterbury Management Resources, Greater Waterbury Health Services, Alliance Medical Group, Cardiology Associates of Greater Waterbury, Access Rehab Centers, Imaging Partners, Waterbury Gastroenterological Co-Management, Harold Leever Cancer Center, Heart Center of Greater Waterbury, Valley Imaging.

We are proposing that this network be acquired by Prospect Medical Holdings, a privately owned company that provides health care services in Rhode Island, Texas and California. This means that we will substantially sell all of Greater Waterbury Health Network's assets to Prospect Medical Holdings. Ann Zucker, Greater Waterbury Health Network's attorney, will provide the detail about the transaction in a little while.

As you know, as the mayor just said, this is not our first time down this road. Greater Waterbury Health Network, Waterbury Hospital has gone through this regulatory process for a proposed partnership. We don't plan to spend much time this evening rehashing those processes. There was

certainly a great deal of information available through the last few years. Tonight is about looking forward to the future of health care in this region.

A great deal has happened in five years since Greater Waterbury Health Network Board of Directors determined that a strategic capital partner was necessary to ensure the sustainability of our network and hospital, while we still believe this is the true path forward, particularly in a rapidly changing environment we are operating in.

The significant changes we anticipate in the health care industry are five years ago, in the future, today; they are upon us. And we're not talking about incremental change. We are talking about monumental change that is very rapid. For Waterbury Hospital and our network, this has meant significant challenges, but also tremendous opportunities, and we believe that the proposed transaction with Prospect Medical Holdings is one of those opportunities. We will be hearing a great deal more about this throughout this evening.

The Greater Waterbury Health Network board's transaction task force that has been guiding our search and process for a strategic partner, our

goals for a partnership, included one that would enable us the likelihood of coming to a close on a transaction. This meant a more simple structure for the proposed partnership as well as a transaction that would be dependent only on our organization and our partner, a partner that would provide the capital to address the immediate needs while making a long-term commitment for strengthening and growing services to our community, one that offers the least disruptive to our services and employees, a partner that has experience in a new model of health care payment and delivery, not only for the hospital, but for all of the components of the network.

Directly after Tenet left the state of Connecticut, our investment bankers immediately looked at our options for a new partner. While some health care companies and organizations reached out to us, we again looked closely at the initial proposals that Prospect submitted to us over two years ago. Frankly, when we chose Vanguard as our partner in 2012, which was then acquired by Tenet, Prospect was also a top contender. However, we were concerned that Prospect didn't at that time have any hospitals in the northeast, but now they have two hospitals in Rhode Island and they're in the process

of acquiring a hospital in New Jersey.

The task force and the Greater Waterbury Health Network Board of Directors have conducted extensive due diligence on Prospect. Our physicians and leaders have visited Prospect headquarters in Los Angeles and hospitals in Rhode Island. Prospect representatives have met with our employees, medical staff, labor unions, elected representative, state leaders, payers, the mayor, our Greater Waterbury Health Network membership, and a whole host of others. The Greater Waterbury Health Network Board of Directors receives regular updates on the proposed partnership with Prospect.

Our extensive review and due diligence has demonstrated that Prospect Medical Holdings is the right partner not only for Greater Waterbury Health Network, but for all of our community.

Prospect offers innovative and proven models for delivering high quality care at low cost, has a track record of strengthening health care systems, not just the hospital, with the goal of providing high quality care and a community care that provides the health and quality of lives of individuals and their families. This means

expanding access points within the community to make it easier for you and your families to see a doctor on a regular basis. As an example, in California Prospect arranged for pharmacists to visit patients's homes and to help make sure they're taking the correct medication and correct dosages. Prospect also can coordinate transportation for people to ensure they make up their follow-up appointments. Additionally, in an effort to break down barriers to good health, they provide translators to assist patients in assessing health care services. They will also address our immediate capital needs while committing to a long-term investment in health care services. In their short time in Rhode Island, Prospect has expanded Charter Care Physicians Network, expanded ventures for an outpatient oncology center and invested over 10 million in strategic capital purchases.

Prospect has experience with stringent regulatory environments given their recent acquisition in Rhode Island which increases the likelihood of closing a transaction here in Connecticut with its regulatory environment.

We are excited about the opportunity of our network to become part of Prospect. This

represents the future of health care. Their approach to coordinated care for patients, population management is making a difference to thousands of people in the communities they serve.

Before we turn to the details of the transaction, I'd like to have Darlene Stromstad, President and CEO of the Greater Waterbury Health Network, talk about what is happening at Greater Waterbury Health Network. Darlene.

MS. STROMSTAD: Thank you, Carl. And, you know, I feel like after the Mayor's speech, all the rest -- spoke to us, that all the rest of us really don't have much to say, because I think his message was so great and he nailed it.

I look around the room and I see a lot of familiar faces here, and many of you have been on a long, long journey with us, and I want to thank you for your continued support, but I want to bring us back to why we're really here today and why a strategic partner is necessary for the Greater Waterbury Health Network.

First, we need to still have access to capital and afford investments in our organization. We need to improve our financial condition and reduce or eliminate our debt. We want to

participate in new payment systems and delivery systems, and a partnership with Prospect will allow us to do that. We also want to protect, preserve and grow local asset -- access, sorry, to services.

Our industry is quite simply changing rapidly. We are moving from a fee for service to a pay for quality outcomes. Basically, what this means is that our payment source is turning 180 degrees which requires that we have systems and structures in place to respond to this changing industry. An organization like Waterbury simply cannot do this alone, but with the resources, the experience and the knowledge of a company like Prospect, not only can we join the future, we can become a leader in the way health care is delivered in the state of Connecticut in the future.

There continue to be challenges in the financial reimbursement of health care. We see continued payment erosion from the federal government through Medicare, declining levels of payment from the state, Medicaid. The payment reforms are putting more financial risk on the providers. We will continue to have pension obligations that we will honor, and we are facing, like many other businesses, with rising costs. All

of these factors mean that it's harder and harder for us to have the resources to invest in the future of our organization.

As you know, in 2010, the board of Greater Waterbury Health Network made the farsighted and right-sighted decision to find a capital partner for our organization. They were kind of ahead of their time. And since then you know what's happened because you've been on the journey with us to the disappointing end of our transaction this January.

At that time our organization made the very concrete decision that we were going to operate on two paths. One, we were going to do everything we possibly could to strengthen and expand the services of Waterbury Hospital and of the network with our limited resources and that we would also work to secure a strategic capital partner to ensure the long-term sustainability of our organization.

Whether alone or with Prospect, this is an organization that has long honored our focus on keeping our promise to our patients. We've done that in the past; we are doing that in the present; and we will do that in the future; our promise to our patients that they will stay at the center of everything we do in spite of any distractions, in

spite of any distractions, and we have had many.

Every week, every week I hear from patients who reach out voluntarily to tell me about the difference we've made either at their stay in the hospital or with a family member. So our -- what the mayor said about us being very meaningful on a real personal level to the people of this community, that is real, and we see it demonstrated every day.

We will continue, as we have in the past, to make quality and safety the foundation of the way we organize our work. And I am very proud that just last week we were selected by US News and World Report for being a best regional hospital.

We also have tried to keep up with some investments in our organization and recently brought on the XI robot, which is the newest generation of robot available. We've invested by replacing our CAT scan and C-arm. We're doing navigational spine surgery, which is new for our organization, and we are also using ultrasound-guided pain blocks with orthopedic patients who are having a lot better recovery time because of the less pain. We're doing what we can, but there's still so much more to get done.

We have remained and will continue to remain dedicated to providing education and training and making sure that we are reaching out and ensuring that there are the next generation of caregivers, whether that's through our residency programs or working with local colleges to help prepare nurses to come to work in our organization. PA's, respiratory therapists, pharm d's are coming through, and I know I'm forgetting some of the other many health care providers that we teach and train.

One of the things that I am most proud of Waterbury Hospital is the role that we have played and will continue to play in advocating, advocating for those people who are most at risk. This is an organization that reaches out and identifies young people who are most at risk and help teach them and train them and get them prepared for their education. We work with their parents to make sure they, too, have the skills they need to become good citizens of Greater Waterbury.

As individuals we have many, many people that donate their time, their money to all sorts of organizations in this community. The community matters to us, and I think we matter to them.

With a partnership with the transaction with Prospect Medical Holdings, we believe that this will secure the future of care and access for a population that so deserves world class health care. We have an aligned vision, mission and values with Prospect. They have a strong reputation for being strong partners with the medical staff, which we'll hear about in a minute and we think is very, very important to this medical community. They have extensive risk management experience, a long history of population health management, and I think very importantly they have a track record of competing successfully against large for-profit and nonprofit health care systems.

And the development of our relationship with Prospect begins now. We are talking about value-based contracts, and we are presently organizing an IP, an independent physician association network.

I think that the folks from Prospect who have spent much time with our organization see what I see and what our organization sees, and that's while there's much to be done, there is much opportunity ahead of us.

Dr. Carl Sherter, would you please come

and share your thoughts with us?

MR. SHERTER: Good afternoon, good evening. I'll try not to be repetitious. I did dress like the mayor. We got the memo. My name is Carl Sherter. I'm the recent chief of staff of the hospital. I'm an original member of the task force that examined the hospital's opportunities with various capital partners. I'm a practicing pulmonary critical care physician. I'm in private practice and an attending physician at both Waterbury and Saint Mary's Hospitals.

I'm most proud of that I'm the chairman of the state of Connecticut's Medicaid, Pharmacy and Therapeutics Committee. I've served as a volunteer since the inception of this committee. I helped write its bylaws and have chaired every meeting for the last 12-plus years. This committee has saved the state tens of millions of dollars, provided the most liberal lists of medication to Medicaid patients. I understand delivery of quality health care to the underinsured. These are our most vulnerable patients.

Over the four years we've looked for a capital partner, health care has changed, and we have changed our goals, and this is good. Under the

Affordable Care Act, health systems will attempt to keep patients healthy and keep them out of the hospital, a good thing. This will require a robust system of care, data driven with ancillary services that provide the best care available to every patient. Every health care system is starting to build this model. Our chosen partner, Prospect, has the system in place and has a proven success with the system in multiple states, as you've heard. We'll be up and running in months, not years, and that's very very important to this city.

Part of my due diligence was to visit two hospital systems in Rhode Island that Prospect acquired about a year ago. We met with their board president, their CEO, the chief nursing officer and six physicians who practice within the system. One physician was in private practice. The others are voluntarily employed. And this is important to the physicians. We got to spend nearly two hours with this group, and it wasn't limited. We spent as much time until we ran out of questions, and there were lots of questions. They said the best way to sum up their experience with Prospect was that Prospect was real and delivered all that they promised. Okay, I'm simplifying that, but it was true. They said

the patients are happy and get much better care than the old way of practicing medicine.

In Rhode Island, Prospect is eagerly taking on the Medicaid population. Hundreds of physicians have signed up on the first year. They like the new model that Prospect offers.

This venture will be good for the proud city of Waterbury. Our population is older than most other cities in Connecticut. The poverty rate is 20.6 percent. Unemployment is 13.1 percent. This venture, as the mayor said, will help stabilize our city and help our city move into the next phase of its existence. This is my editorial, maybe a city of health care and education. I like that thought.

Waterbury has provided excellent care to this community, it's been mentioned. I am proud of the over 1,000 physicians we have trained, many still in our city and in our area. I'm proud of the nurses, certified aids, respiratory therapists, physicians' assistants and pharmacists and probably more that we've trained. I'm proud of the staff of the hospital earning numerous awards for quality health care in spite of the hospital's financial constraints. You can not believe how proud we are

when we get one of these awards, not because it's ego, but because we know we're doing the job we ought to do. This is very important to the physicians and the staff of the Waterbury Hospital, a very friendly staff that all get along very well. We call it "the big group."

As I stated, for the last four years I've represented the staff of Waterbury Hospital and the patients that this hospital serves in its attempt to find a capital partner. I've been at every meeting. Prospect has met numerous times with the physicians who practice in Waterbury. The physicians have asked every question and gotten honest answers. They support this venture.

After almost 40 years of practice in Waterbury, I've seen its problems as a stand-alone hospital. We have an average age of physicians of 59 years. It's getting increasingly difficult to bring young health care workers to Waterbury. They want a secure future for their practice. They want modern equipment to diagnose and treat their patients. They want a stable future with a capital partner that will help with the economy of scale. They know the health care model has changed. They want to hit the field running with a proven system

that Prospect offers.

The people of Waterbury want health care in their own city, and this is important. This is a city of community and family values. Families support each other. Many of my patients come to my office with family members. They all ask, Is it going to happen? We answer, We all hope so. We need a capital partner to make this happen, and Prospect will be an excellent choice. Thank you.

MS. ZUCKER: Good morning. My name is Ann Zucker. I'm the hospital's lawyer, and I'm going to lead you through some very thrilling statutory requirements about our process and then tell you at a high level about the structure of our transaction, our post conversion foundation and where we're going and how long it's going to take, we hope.

So every time that a for-profit entity comes into the state and wants to take one of our nonprofit hospitals and make it a for-profit entity, the attorney general's office and the Department of Health division of Office of Health Care Access get involved. This is called a "conversion process." And these two agencies review the statutes and our applications concurrently, so they run along

parallel tracks.

So we've already filed our request for determination, and this is the next part of the process, that is, our public hearing. So you're at the very beginning of our process with us. So within 30 days after we filed our request for determination, we're holding the public hearing. It's being transcribed and will be available to our regulators and to the public, as Carl Contadini had mentioned.

We expect that the regulators will determine that this is a conversion process, that they will issue an application fairly shortly.

So the request for a determination -- I know that Carl covered this information earlier, but it is really the focus of our hearing tonight -- is a description of the buyer and the seller, a description of the transaction, which as you've heard is an asset purchase of substantially all of the assets of the network and its affiliates and subsidiaries. The cost of the transaction is $100,000,000, and we'll talk a little bit more about what that's comprised of, but most importantly, there are no changes planned to either our service area or to the services that will be offered.

Carl mentioned that we have a list of subsidiaries and affiliates that are going to be acquired, that is, that Prospect will step into the shoes of the Waterbury Hospital entity. You'll note that one entity that's not on here is our child care center. That's a very beloved entity, and that will not be part of this transaction. It will continue to operate, though.

So our partner in this transaction is Prospect Medical Holdings. We have some of the representatives here with us today. They're based in Los Angeles, California. They consider themselves a health care services company, not an owner of hospitals. They have a much broader view of themselves and their role. They do have 13 acute care hospitals in Rhode Island, Texas and California. They're in the midst of an acquisition process in New Jersey, and the last two nights they were up in the eastern part of the state because they have letters of determination pending with respect to the Eastern Connecticut Health Network hospitals, Rockville and Manchester hospitals. They have about 9,000 physicians affiliated with them, and it's a very physician-centric organization.

So moving on a little bit about what

our process is like, we do expect that the regulators will consider this a conversion; they will issue us an application. The application process is very, very thorough, very deep. There were literally thousands and thousands of pages filed. There were public hearings. It's a very transparent process, and the regulators have been very committed to making information about the process available to the public.

The application will go into depth about the identity of each of the applicants. It will talk about the diligence process of our board in reviewing Prospect and Prospect's diligence of us as well. We will have a fairness opinion by the entity that gave us fairness opinions in the past. We expect a favorable opinion on the fair market value of the transaction will be issued relatively shortly.

The application will also discuss the terms of the transaction. It will include copies of all of the transaction documents, for example, the Asset Purchase Agreement, which is the primary document. And it will also detail the plans of the foundation that will hold our charitable assets after the closing.

So the standards that the attorney general will look at are outlined in the statute. So, remember, he's looking at the statute along a parallel track with the Office of Health Care Access. So the attorney general must deny an application if the transaction is prohibited by Connecticut statutory or common law that deals with nonprofit entities, trusts or charities. He must deny it if the nonprofit hospital fails to exercise due diligence in either deciding to transfer, selecting the purchaser, obtaining the fairness evaluation or fairness opinion, and negotiating the terms and conditions of the transfer. He must also deny it if the hospital fails to disclose any conflict of interest and if it believes that the hospital will not obtain fair market value for its assets.

Other factors that he considers is whether the fair market value is manipulated to cause the value to be decreased, whether the financing of the transaction will put the hospital's assets at risk; if there turns out to be a management agreement, whether that management agreement is at fair market value. And then finally he looks at the foundation aspects, whether the fair

market value is being transferred to an appropriate entity. In our case that will be a foundation.

Then lastly, he has the ability to request pretty much any information they would like to see that's relevant, and so there's a requirement to fulfill those requests.

The Department of Public Health also conducts its process, and the statutory factors for that are whether the community will continue to have access to high quality and affordable medical care and that there's a commitment from the acquiring party that they will continue to provide care to the uninsured, the underinsured, and in the situation where insurers or providers have an opportunity to invest are some safeguards that must be in place to avoid any conflict of interest in patient referral.

So, finally, they also have the certificate of need conditions that are appropriate and apparent in each of those proceedings so that as public need, the continued access to health care, what the financial impact would be on the health care system across the state, whether the proposal will improve the quality of care, the accessibility and the cost effectiveness of the health care delivery system in our region.

So this is what the process looks like laid out on a time line, and honestly, we're all the way over on the left. This is the first public hearing that you see. The chart shows it will then get an application. We have 60 days to respond. The regulators have an opportunity to ask additional questions, and that could go several rounds. Ultimately, they will deem the application complete, and there will be public hearings and perhaps some additional interrogatories or additional questions.

And, finally, the regulators will issue a decision. They will either accept it as proposed, accept it with conditions, which is what happened last time, or deny the application.

So that's what the regulatory process looks like, and it's a long, hard road, and we welcome your assistance in our journey just as you gave it last time.

So this transaction is an asset purchase transaction. It's not a joint venture as we had in the Tenet transaction. It will, of course, include the continued operation of the hospital. There will be an advisory board that includes members of our community. Prospect has committed capital to improve the facilities and

equipment as well as to recruit new physicians to our community, to Dr. Sherter's point that we need to continue to be able to recruit younger, strong physicians into our community. Prospect has agreed to hire all of our employees and to assume our contracts, and they've committed to continue charity care and adopt the charity care policies that we have in place today.

Very briefly, the transaction overview: The assets that are included are the assets that comprise most of our health care giving assets, so that is the hospital, the physician practices, the interest in the joint ventures, for example, the imaging ventures, the heart center, the cancer center.

Excluded from the transaction are donor restricted funds, cash and investments. Our cost report settlements we're keeping, the child care center, as I mentioned before, and our captive insurance company that deals with our professional liability claims.

We are receiving a cash purchase price of $45 million. We will need to use some of those funds to address our outstanding liabilities, for example, our indebtedness which is comprised of some

CHEFA, tax exempt bonds. We'll address the unfunded pension plan liabilities, our captive insurance liabilities for the medical malpractice claims. Workers' compensation claims will be covered. There's some asbestos liabilities that we'll be insuring, are covered as well. And there will be some transaction costs.

The other part of the $100,000,000 is the $55 million that Prospect has committed to capital, a capital commitment which will include some hard assets, but also the development of a network within the community and physician recruitment.

So finally, our net assets will go into a foundation. There will be a new entry created that will hold our charitable assets, and we'll be able to provide some grants and so forth for health care needs in the future. We will ask for some representatives from the community to serve on this board and perhaps an advisory board as well. The foundation is anticipated to focus on community health needs, and it will be those directors of the entity that will manage and oversee the charitable assets that the attorney general makes sure that we are looking after.

And so I'll turn it back to Carl for the comment period.

MR. CONTADINI: Thank you, Ann. Thank you, Dr. Sherter for saying a few words here today. I think those were well done.

Before we start the question-answer period, as the mayor said, this has been a long road, and the road is not over yet, but I think with our working with Prospect, their determination to see this to the end, I think we're on that road right now to get to a finish line. And so to me that's very important. This is a hospital that's very important to me. I was born in this hospital. So to me this is the right thing to do.

So with that, and with Ann giving you a little bit in regards to the transaction, I'm going to get into the question-and-answer period. And I just want to remind, we want to make sure everybody can come up and talk. If you haven't signed up and you'd like to talk, you can go to the registration desk. I'm sure somebody's there to get your name on the list. And I encourage you to come up and talk. If there's something that's on your mind, it's important. This is a very transparent -- we're being very transparent here what's happening. We

have no hidden agendas, I can assure you of that. We're trying to preserve health care in this community for the next 100 plus years. That's what we're trying to do. So if there's something on your mind, please come up and talk.

So first on our list today is Paul Pernerewski, I'm hoping I'm pronouncing that right, President of Waterbury Board of Alderman. Paul.

MR. PERNEREWSKI: Thank you. Good evening. My name is Paul Pernerewski, and I am the president of the Waterbury Board of Aldermen.

I'm here this evening to express my support for this proposed transaction between Waterbury Hospital and Greater Waterbury Health Network and Prospect Medical Holdings.

Waterbury Hospital and its parent corporation, the Greater Waterbury Health Network, have been working very hard to identify and pursue the best strategies to ensure a sustainable hospital and health care network for our city and our region. One of the essential elements which has been identified is the need for a strong capital partner moving into the future. While there have clearly been obstacles and challenges along the way, the

proposed acquisition by Prospect Medical Holdings may be the right partner at the right time. Prospect brings a wealth of knowledge, information and expertise about how to thrive in the new era of health care. With their hospitals, physicians and health networks in Rhode Island, California and Texas and very soon in New Jersey, they are innovators and leaders in improving the health and quality of life for patients and communities, and they have demonstrated that they can strengthen care and outcomes while also holding costs in check.

Just as importantly, they have pledged to invest in our community. This transaction includes upgrades to Waterbury Hospital and to long-term growth and expansion in outpatient services which will help bring care closer to home for so very many in our region, and that investment is so very important to our continued development as a city both economically and as a community.

We're delighted that Prospect and the Greater Waterbury Health Network are working toward a partnership that will bolster health care for our city and surrounding communities and bring broad and lasting benefits for patients and community members.

I'm looking forward to the

opportunities ahead and urge the state regulatory agencies to help move this acquisition forward swiftly. Thank you.

MR. CONTADINI: Thank you, Paul. All right. Next, Dr. Jim Gatling, New Opportunities.

MR. GATLING: Good evening. My name is James Gatling. I'm the president of New Opportunities, and I'm also a member of the Greater Waterbury Health Network Board of Trustees. I, too, have seen this movie before, but this time it feels different. It feels right. It feels that Prospect is the right partner for us.

For those of you who aren't familiar with New Opportunities, I would like to take a few minutes, a few seconds to tell you about who we are.

We were formed in 1964 as the result of President Lyndon Baines Johnson's war on poverty. We are called the "Community Action Agency." We are one of 900 in this country. Our service area is Waterbury and the 27 surrounding towns. We have offices in -- we are headquartered in Waterbury, but we have offices in Meriden, Torrington, Thomaston and Danbury. We operate 50 different social service programs designed to eliminate poverty and help

those in need. Our services range from early childhood education to programs for the elderly. Also, a point of note, that our organization is the fourth largest employer in the city of Waterbury.

We understand the wide range of needs in our community, particularly those who are most vulnerable, low income and elderly residents, those who are medically frail, our children and those who have children. I have seen the vital role that health care plays in everyone's lives -- individuals, families, companies, the community as a whole. I believe that it is essential that every single individual in this community have access to high quality health care. It contributes not only to our health, but to the quality of life and the economy in this region. Let's remember, a healthy workforce is a productive workforce.

Waterbury Hospital has been fulfilling this role for the Greater Waterbury region. Our hospitals strive to provide access to quality health care for all, and we have been doing a tremendous job in spite of the challenges we have been facing over the last few years. Waterbury Hospital does much more than take care of people when they're sick. The hospital is woven into the fabric of the

community helping to improve the health and quality of life for our residents.

You will find Waterbury Hospital at virtually every community event, usually playing an active role in helping people access care, teaching them how to take care of their health. The rapid and accelerating change in today's health care environment makes it difficult, if not impossible, for stand-alone hospitals to survive. This is the situation with Waterbury Hospital.

We have known for years that the long-term sustainability of the hospital and the Greater Waterbury Health Network requires a strong strategic and capital partner, and we have been actively pursuing the right partnership for both our network and our community.

After learning about Prospect Medical Holdings' innovative approach to coordinating care for our community, I am convinced that this is the right partner for our hospital, our network and our community. Prospect brings a unique model, expertise and experience that will ensure that the community has expanded access to all health care services, not just hospital care.

I am strongly supporting the

acquisition of the Greater Waterbury Health Network by Prospect Medical Holdings because it will bring tremendous benefits to our community's health and quality of life. Thank you.

MR. CONTADINI: Thank you, Jim. Next Dr. David Pizzuto, Greater Waterbury Health Network.

DR. PIZZUTO: Good evening. My name is Dr. David Pizzuto. I'm the vice president of Medical Affairs and the Chief Medical Officer for Waterbury Hospital and the Greater Waterbury Health Network. I was born in Waterbury. I was raised in Wolcott and have been affiliated with Waterbury Hospital for 31 years, the last 28 as a practicing internist with a practice at 1211 West Main Street, in Waterbury.

During the course of my medical career I have witnessed many changes in health care, but nothing as dramatic as the changes occurring today. Currently hospitals, physicians and all segments of the health care environment are challenged as never before by the major shifts occurring in both health care delivery and health care payment. The overwhelming goals of these shifts are to improve quality of care, improve patient health care outcomes and to reduce health care costs.

I believe that Prospect Medical Holdings is the organization that can help Waterbury Hospital and our affiliates successfully navigate the changing seas of health care. Prospect has the experience to bring all facets of health care from physician practices to ancillary care to acute hospital care to care management together to effectively manage and coordinate health care for our patients and the people of the Greater Waterbury area.

Additionally, their innovative health care models offer the best possible care for today's complicated and complex patients. Over the last couple of months I have seen firsthand how Prospect delivers on its commitments to improve the health of patients while also controlling health care costs.

I was recently part of a group that went to the Rhode Island hospitals owned by Prospect as well as to Prospect's headquarters in California. We were all quite impressed with the investment, the innovation and the energy that Prospect brings to health care delivery and to health care payment.

We here in Waterbury have the opportunity to set the standard in this new era of health care with Prospect as our partner. We have

the ability to become leaders in population health management and coordinated care utilizing Prospect's resources, expertise and experience.

I believe that the acquisition of the Greater Waterbury Health Network by Prospect Medical Holdings will benefit the physician community, benefit the hospital and its affiliates, but most importantly, benefit our community, and I wholeheartedly support this transaction. Thank you.

MR. CONTADINI: Thank you, Dave. Next, Loraine Shea, Easter Seals.

MS. SHEA: Good evening. My name is Loraine Shea, and I am the president of Easter Seals of Greater Waterbury, a nonprofit organization serving the rehabilitation, education and employment needs of the community for over 55 years. I am also a resident of Naugatuck and a consumer of the Greater Waterbury Health Network services.

I would like to express my sincerest support for the proposed transaction between Prospect Medical Holdings and Greater Waterbury Health Network, the parent company of Waterbury Hospital.

Having spent the last 10 years of my professional career in various health care industry

roles in Waterbury, I have witnessed firsthand the challenges the health care industry has faced and the impact these have had on Waterbury Hospital. I am confident that Prospect's model of comprehensive regional care, its focus on growth of services and population management will serve the Greater Waterbury community well.

Prospect has demonstrated in its previous transactions that it is innovative, creative and forward thinking. It has also brought much needed capital resources to its partners, and this continues to be a significant need for Waterbury Hospital as we've already heard.

Prospect Medical Holdings will provide the stability, resources and investment and technology that is needed to continue to serve all the health care needs of the Greater Waterbury area.

Having worked alongside the employees of Waterbury Hospital, many of whom are here tonight, I feel I can confidently say that this transaction is strongly desired by those that take care of the patients that enter the hospital or seek care at a hospital outpatient facility on a daily basis. These caregivers are some of the best, caring for some of the sickness and most vulnerable

individuals from our surrounding towns, and they want to see Waterbury Hospital continuing to thrive throughout the next 125 years.

I am also convinced that Prospect Medical Holdings believes in the promise that Waterbury Hospital holds as the gold standard, putting patients first, and that, after all, is what health care is all about, the patients.

The proposed transaction will allow this fine institution to continue its great work for the community it serves. I urge state regulators to approve this conversion. Thank you for your time.

MR. CONTADINI: Thank you, Loraine. Before we continue, I'd like to introduce Senator Joan Hartley.

SENATOR HARTLEY: Good evening to you all. I saw Darlene yesterday and told you I'd be stopping by. I see a lot of familiar faces.

So, first of all, I want to welcome you to Connecticut, because I know you've been in other places here in the state, but also to Waterbury. This is my district. It's the heart of my district. I represent Waterbury, Middlebury, Naugatuck, and so this is going to be a long conversation, and it's a very important one.

We were just over at the community college yesterday talking about building the skilled pipeline, developing a med tech program, providing the skilled employees and workforce that is necessary to have an excellent program. I have read about you. I'm going to continue to learn a lot more about you. My apologies, I have not heard your pitch, but I know there is going to be time for that, and so we'll get to know each other very well.

But let me just say that this is a community that is a very engaged community. You have looked at our demographics. You are understanding who we are. But it is so important that we have world class health care here.

Now, it wasn't that many years ago that we were all working very hard to try to get cardiac care here, because what was going on was -- what was it, the ship and drip, the drip and ship onto Route 8, Route 84, totally unacceptable, and so with a great coming together of many of the people in this room, we were able to make our case through the regulatory process and to achieve that expertise and care. I am very concerned that we continue to grow those kinds of specialties here.

I'd also like to mention the fact that

some years ago, and I don't want to mention how long ago, we came together -- and long before Darlene, she's kind of a baby here -- to build a child care center here, the first one in the city of Waterbury. It was with state resources, and it has grown, and it basically set the threshold for everything that came after that, and to this day it is still a very excellent program. I am very concerned that we continue to operate that and support it in the same way that it always has, that this institution has.

And so with that, I understand the challenges that the health care industry faces. I myself, along with Craig Leroy here, have had many frustrating moments, and Darlene has been with us in the trenches on all of that, and that's, you know, probably not going to go away really quick, but nonetheless, you have people in this room and in this community who have incredible skill and resources and knowledge and most of all the will to make this the very best world class system.

So I read that you are -- you run things from distant places, and that concerns me. I like home town bankers. I like, you know, home town resources. We all know how comfortable you feel with that, but I understand the universe of what it

is, and so going forward, I want to know that we have the ability to be recognized and have resources as if they were home town.

So as I said, it's a long process. I'm here on behalf of the entire state delegation, and we will be rolling up our sleeves working with you hand and glove as we go through this. So once again, our welcome to you and look forward to many conversations.

MR. CONTADINI: Thank you, Senator Hartley. Tom, would you like to say a few words in regards to that?

MR. REARDON: Senator, thank you so much for your comments. I appreciate it very much. And by the way, thank you all for coming. Mitchell is from Los Angeles. I'm from Boston. And we have a philosophy, and I just wanted to -- Senator, you're misinformed on one point. We believe all health care is local. We cannot run things from Los Angeles. And so we are going to support the local management team, and we're going to have a local advisory board, and we are going to provide support for it, because it has to be local. And as I said, you folks are -- you know this community better than Mitchell or I will ever know this

community. So we need your input and your help on this. But thank you very much for your welcoming, and we're thrilled to be here. Thank you.

MR. CONTADINI: Thank you, Tom. Next I'd like to have Brian Emerich of Access Rehab.

MR. EMERICH: My name is Brian Emerich, and I'm the president for Access Rehab Centers, which a local rehabilitation company that has a partnership between Waterbury Hospital and Easter Seals of Greater Waterbury, and I'm also an occupational therapist by background.

I would first like to thank you all for the opportunity to share some thoughts regarding the proposed acquisition of Waterbury Hospital by Prospect Medical Holdings. I would respectfully ask that when considering this transaction, that we all need to take into account, into consideration that changes in the health care delivery system are coming in a pace that several years ago none of us would have dreamt would be possible. These changes are redefining the way health care facilities are reimbursed, how they treat patients and who they treat. The very foundations of the way that business is conducted is being changed. Even the definition of success is changed.

Health care is moving from quantity to quality. I for one applaud this move, and if it is done well, I truly believe that it is a win for the patient, it's a win for a quality health care system, a win for those paying for health care, and a win for the clinicians who will be able to focus on prevention and healing.

In many cases the best strategy for success is finding someone who can guide you and mentor you through the change process. Waterbury Hospital has chosen well with Prospect. They have the record for success in competing in this new market. They have a cutting edge business model that is both competitive and brings a fresh new way of embracing quality and empowering providers to focus on health management.

Everyone knows that hospitals are struggling under reduced reimbursements as well as significantly larger numbers of people who require services. As with much of Connecticut, our health care institutions are sloping down a very dangerous trend, reduced funding and increased demand. It is obvious that we are headed in the wrong direction. I ask you to remember that the first rule when you find yourself in a hole is you have to stop digging.

We need a new way to manage health care and health care costs.

Prospect brings new ideas, a proven track record and the capital that it will take to implement the necessary changes.

I have worked with Waterbury Hospital for over 15 years, and I can honestly say that the care of Waterbury Hospital today is the best that I've ever seen it in all those years. It is of a higher quality, and it is provided with a significantly higher degree of efficiency as well. Even with all of those positive changes, I can say that the expectations that are on hospitals today make it extremely hard to provide care and to keep the doors open. How many of the business owners in this community could stay open if there were an ever-increasing number of people walking through their doors who were required to pay below what that business' costs were for the goods that were being sold?

All across Connecticut we've been hearing about layoffs at various hospitals. Health care is not something we can afford to do like we have been doing in the past, but at the same time, we cannot afford as a society to allow our health

care systems to die on the vine. We have to change the way that we do business. We have to think differently. We have to reward quality providers who provide top quality care at a lower cost than others.

Prospect is willing to accept risk and health care delivery because they know how to prevent hospitalizations and keep people healthy. Isn't that what health care providers in general should be doing?

So why Prospect? I believe that Prospect is a great match for Waterbury Hospital and the entire Greater Waterbury Health Care Network because they see the business opportunity where others have yet to look. They are a clear leader and innovator and they bring a new commitment to partnering with the providers in the community and with the government as well as with payers. It is a model that has proven viable and has flourished elsewhere. It changes the equation. It's a way to mine the inefficiencies of our current health care system, and it reinvents the basic fundamental structure of health care delivery in such a way that going forward everyone should be able to focus and be rewarded for doing so on preventing illness and

reducing costs.

I respectfully ask that we all support the acquisition of Waterbury Hospital by Prospect Medical and, further, that we all support the concept of health management as a means to reinvest health care in our country. Thank you.

MR. CONTADINI: Thank you, Brian. Next I have Lynn Ward, Waterbury Regional Chamber of Commerce, but...

MR. KRECHEVSKY: Obviously, I'm not Lynn Ward. I am David Krechevsky. I am the Director of Public Policy and Economic Development for the Waterbury Regional Chamber for which Lynn is president and CEO. Unfortunately, she was supposed to be here tonight, but she's been delayed by another event, so I'm going to give her testimony on her behalf.

The Chamber serves 13 towns in greater Waterbury and represents the collective interests of more than 1,000 businesses in matters of public policy and economic development, and I'm here to express the Chamber's strong support for this transaction between Waterbury Hospital, its parent Greater Waterbury Health Network and Prospect Medical Holdings.

A strong, viable hospital and network of health care and medical services is critically important for Greater Waterbury and the businesses in our region. These are the resources that employers, employees and their families rely on for the full range of care from primary care to emergency services to state-of-the-art surgical care. The Chamber's public policy programming continually advocates for measures that improve the local quality of life, and we're aware that a strong health care system plays a crucial role in helping companies decide where to do business.

Hospitals today operate on a continually changing, highly competitive environment, and the proposed transaction would provide the hospital and the network with the resources needed to ensure they continue to deliver a high level of care.

As this transaction moves forward, it's important to remember that Waterbury Hospital and its affiliates provide more to this region than just health care services. The hospital is one of the city's largest employers and brings both direct and indirect economic benefits to our region. In fact, a recent economic impact study conducted by the

Connecticut Hospital Association found that Waterbury Hospital contributed more than $463 million to the region's economy in 2013 alone.

In addition, the Chamber's municipal agenda supports initiatives that expand the commercial segment of Waterbury's grand list. Growth in the tax base has a major impact on making the city more attractive to companies looking to expand or relocate, as well as serving to reduce the tax burden on existing businesses and residential tax payers. Because this proposal will provide a significant increase in local tax revenue, it both directly fosters economic development and improves the city's ability to attract future economic development.

Prospect Medical Holdings, meanwhile, will bring new resources, expertise and innovation that will help to meet the mutual goals of the business community and of local health care providers by improving the health of our communities while keeping costs in check. The issue of ensuring continued access to high quality care while controlling and reducing health care costs is a key priority for businesses as well as the health care industry.

Prospect has a proven model of health care delivery and payment system that has demonstrated improved health care outcomes while reducing the cost of care.

One of the more exciting aspects of Prospect's business model, known as "coordinated regional care," is that it brings together all parts of the health care system and community resources to effectively coordinate and manage care for the region's population. It will bring a true system of care to and partnership with many of the stakeholders in Greater Waterbury.

We look forward to the potential opportunities that Prospect offers to our region and our business community. The Waterbury Regional Chamber supports the acquisition of Waterbury Hospital and the Greater Waterbury Health Network recognizing the many benefits it brings for strengthening health care in our communities and contributing to the economic development of our region both now and for the long-term. Thanks for the opportunity to speak tonight.

MR. CONTADINI: Thank you. I see the real Lynn Ward has walked in.

MS. WARD: Great job, David.

MR. CONTADINI: Next I would like to call Dr. Scott Peterson of OptiCare.

MR. PETERSON: Good morning, everyone. My name is Scott Peterson. I'm an ophthalmologist, and I particularly appreciate the opportunity that we have in this community for the hearing that Darlene and the people from Prospect and Mr. Contadini have set up.

I was working in our garden today for a long time because everything is very dry, and I had -- I knew I was going to make some remarks tonight, and I couldn't help but remember that not too many years ago we had a garden party there for the cardiology department at Waterbury Hospital. And the reason that we had that is that I had been on the drip and ship program that Joan spoke about, and I'm here today, that was 15 years ago, but I am still so grateful for being able to water in my garden even when it's hot. And I can tell you -- and I'm sorry to go on, but I have to tell you this -- it was not a fun ride between Waterbury Hospital and Bridgeport. You couldn't help but think "what if." And so having all of these things here will be wonderful.

Just so you know who I am, I live in

Middlebury. I did my internship in Waterbury Hospital in 1971. I've been on the staff of the hospital ever since. I'm one of the founders of OptiCare which is Connecticut's largest eye care provider. I've been a chairman of the Department of Ophthalmology at the hospital. We don't have ophthalmology services now, but maybe they will come back. And I have many, many patients, multi-generational patients. So the future of the hospital is extremely important to me personally for my own health care, and it's also terribly important for all of the people that I take care of.

I love Waterbury Hospital, and I hope very much that whatever transpires has all the virtues that we all want them to do.

I have also been deeply involved over the last several decades in local philanthropy. I was the president of the Connecticut Community Foundation, and I've been active on many boards over the years, and it's this area that I want to address in my remarks tonight, which are, in fact, questions, not questions that can be necessarily answered tonight, but questions that have been alluded to already, but that I think bear continuing scrutiny, and I know that they will receive that.

I realize that the foundation will be separate, but I am concerned that such may not be -- that that alone -- that the paperwork may not alone be enough to fully protect the millions of dollars that donors have provided to the hospital over many, many years. I would like to know how this piece of the financial picture is calculated. I would like to know what outside oversight there will be in addition to the AG and in addition to the local committee. It needs to be completely independent of the hospital and completely independent of politics. It really needs to be a representative of the community.

I remember quite well the very -- at least for me -- the very unhappy results of the tobacco settlement money in Connecticut which really became one giant political honey pot. And I also remember what happened to the Anthem Blue Cross money. That also became a kind of political football that in some respects I still think is somewhat suspect. And out of respect to the hundreds and thousand of donors that have contributed in good faith to a community hospital, a nonprofit entity, I hope that that will be safeguarded in perpetuity.

So will the foundation assets be tapped, for example, for fees for indigent patients such that now the for-profit receives money for their care, whereas before, the hospital, whether for better or worse, provided those services at no cost?

There are many such questions and there are many people, experts in this area, and I certainly don't profess to be such an expert, but I do hope that their opinions will be sought and consulted and that we can all be proud in the end of not only the world class health, which I have no doubt will occur, but of the world class ethical and moral underpinnings of the new venture. So I hope that these questions will be given very thorough study and discussion by the commission and by all parties concerned. Thank you very much.

MR. CONTADINI: Thank you, Dr. Peterson. I'd like to have Ann Zucker address some of those concerns. The -- as we proceeded with this transaction, one of the things that was very important to us was the foundation and how do we preserve that foundation on an ongoing basis. And, again, the important thing is, is when we started on this road five years ago, we went and we told

everybody this is for real, we need to do this, because while we have some assets left, we need to protect them as we move forward. And five years have gone by, and those assets become less and less over time. However, we've done a lot of work in that area, and Ann is really the expert in that area, and she can, I think, put to rest many of those concerns you have. And if you feel that the answers are not clear, I would ask you to readdress them because I think this is important because the foundation is the legacy that will be left from the past. So Ann?

MS. ZUCKER: Hello, Dr. Peterson. How are you? Your concerns were exactly the same concerns that our board had, and Carl just expressed many of them.

The attorney general's office is tasked with making sure that each of those funds is put to an appropriate use. We are required, and the attorney general's office made sure we did this last time, to deliver a copy of each of the instruments that gave funds to the hospital. So some of those instruments go back to the late 1800's, early 1900's, and so we had to track each one of them down, unearthing things from probate courts,

archives in many different towns. There is a fellow at the attorney general's office who pours over the language of each of those specific documents and, if you look at the last decision in our previous hearing, made some very specific recommendations about what could be done with those funds and what could not be done with those funds. So a lot of attention is being spent on each of those individual pots of money.

One of the other things you raised was who would be overseeing these funds and whether there would be any sort of conflict of interest with respect to -- and I guess perhaps you're thinking about perhaps people sitting on both boards of the hospital or the advisory board of the hospital and our community foundation. And I believe that the statute prohibits that from happening. So those -- there will not be any commonality between those boards in order to keep it separate from any conflicts of interest. So you should get some assurances there.

And then I think I'm going to answer the last question you asked, and that is, could the funds from our charitable foundation be used to provide indigent care that our successor for-profit

hospital should be providing, and the answer to that is no. Prospect has agreed to step into our shoes on the charity care policies that we have now. It is not permissible for a tax-exempt organization to provide funds that will benefit even indirectly a for-profit. And I'm sure they've been through this up in Rhode Island just a year or two ago. So I don't think there's any expectation on Prospect's part, nor our board's part, that those funds would be used to benefit the successor hospital.

We very much appreciate your concerns and your voicing them and taking the time to think about those things, because they're hard things, and our board has paid a lot of attention to them. So thank you, and thank you for being a hospital supporter for a long time.

DR. PETERSON: You're welcome, and I know the good people have thought of these things.

MS. ZUCKER: Thank you.

MR. CONTADINI: Thank you. Okay. At this point in time I'd like to offer one more time if anybody here in the audience would like to ask any questions. The decision-makers are all here in this room. Now is your time. And I think that if you'd like to, I would -- you know, we're at the end

of the list, so I would like to offer that one more time. Again, our objective here is to get participation from the public. And your questions -- you know, I know this is a hard thing for some people to do because they think their question isn't important, but it is probably important. We don't know all the questions that you have on your mind. So I'd like to give you a couple minutes to think about it before I conclude this meeting. So I give you two minutes, and if you'd like to -- if you'd -- somebody would like to think about asking some questions, I would encourage you to do so. So the clock is ticking.

MR. RHODES: Robert Rhodes, retired United Methodist minister, and also I was with the hospital 12 years in the pastoral care department. I'm just so happy that the good doctor, my ophthalmologist, I can still see, and I am so happy about the foundation. The predecessor with the previous group, I talked with them, Mr. O'Meara, on a couple occasions about the foundation because I haven't heard much about it.

Secondly, as you know, some of my brothers and sisters in the clergy attempted to get into the hospital to present their cause. I did not

know about that.

I look at the foundation -- and I realize this isn't a question -- as a very creative possibility to link the hospital with the community and their concerns. And we talked recently about people ruling us from afar, and you answered that very well, but I just want to thank him for that, and I believe the foundation can be a very creative instrument and address a lot of the needs of the community. Thank you.

MR. CONTADINI: Thank you.

MS. ORGANIC: Hello. My name is Carol Organic, and I'm a member of the Waterbury community. I've lived here for approximately 30 years. I'm originally from Massachusetts, and I had the honor and privilege of having surgery at Waterbury Hospital most recently about six months ago. I had both my hips replaced by Dr. Keggi, and I was very happy with the outcome and my experience.

I have one question for all of you, and that is -- I don't know if you can answer it today, but I think there have been a lot of joint ventures with Saint Mary's Hospital in the past, and I didn't know how those were going to be separated. Your cardiology, your surgery center, your cancer center,

etc., how are those going to be broken up into the community. I know you probably can't answer it today, but perhaps in the future.

MR. CONTADINI: I think we can give you an answer. Ann?

MS. ZUCKER: Those are very important services in our community, so thank you for bringing that up. Perhaps I should have covered that in my presentation.

So you're exactly correct, that we're working through the legalities on those issues, but I understand that Prospect, as well as our board, is committed to having those services continue to be in our community. So we're working on the fine points, but we're all committed to continue to have cardiology and oncology services in the community.

MR. CONTADINI: Okay. Is there anyone else? Two minutes is gone. Okay. With that, I'd like to thank everybody for coming here this evening, for your participation and your attendance. It's very important. And this concludes the public hearing, first public hearing, at Waterbury Hospital. Again, thank you very much.

(Hearing concluded: 06:37 p.m.)

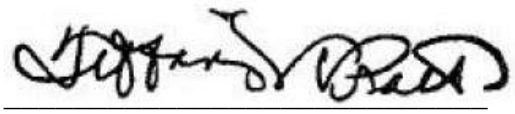
C E R T I F I C A T I O N

STATE OF CONNECTICUT:
COUNTY OF HARTFORD:

I, TIFFANY V. PRATT, a Notary Public duly commissioned and qualified in and for the State of Connecticut, do hereby certify that the foregoing 65 pages are a complete and accurate computer-aided transcription of my Stenotype notes taken in the matter of the Public Hearing re. Greater Waterbury Health Network/Prospect Medical Holdings Transaction taken on Wednesday, August 5, 2015.

I further certify that I am a Notary Public duly commissioned and qualified to administer oaths in the State of Connecticut.

In witness whereof I have hereunto set my hand this 11th day of August, 2015.



Tiffany V. Pratt
Notary Public

My Commission expires:
July 31, 2020

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EXHIBIT Q16-1

SUPPLEMENTAL CON APPLICATION

Supplemental CON Application Form

Acquisition of Equipment

Conn. Gen. Stat. § 19a-638(a)(10),(11)

Applicant: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Name: Acquisition of Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.

Affidavit

Applicant: Prospect Medical Holdings, Inc.

Project Title: Acquisition of Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Sam Lee (Name), CEO (Position – CEO or CFO)

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

Signature 10/16/2015 Date

Subscribed and sworn to before me on _____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____ Ph. see attached.

JURAT

A notary public or other officer completing this Certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on
this 16th day of OCTOBER, 2015,

by * * * SANG BUM LEE * * * * * * * * *

proved to me on the basis of satisfactory evidence to
be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

Signature E. Lucas (Seal)

AFFIDAVIT

Applicant: Greater Waterbury Health Network, Inc.

Project Title: Acquisition of The Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Darlene Stromstad, FACHE, President/CEO of Greater Waterbury Health Network, Inc. being duly sworn, depose and state that Greater Waterbury Health Network, Inc.'s information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature

10/19/15
Date

Subscribed and sworn to before me on October 19, 2015

Notary Public / Commissioner of the Superior Court

My commission expires: 7-31-16

{W2597163}

1. Project Description: Acquisition of Equipment

Waterbury Hospital in Waterbury, Connecticut provides a broad range of imaging services on its hospital campus including computed tomography ("CT") scanners, digital mammography, ultrasound, diagnostic x-ray, interventional radiology, MRI (through Greater Waterbury Imaging Center) and nuclear medicine.

Greater Waterbury Health Network, Inc. ("GWHN"), the parent company of Waterbury Hospital, is contemplating entering into an Asset Purchase Agreement (the "Asset Purchase") with Prospect Medical Holdings, Inc. ("Prospect" or "PMH") with the intent to sell substantially all of GWHN's assets to PMH or one or more affiliates of PMH. As part of the proposed Asset Purchase, a PMH subsidiary that will continue the operations of Waterbury Hospital will acquire the CT scanners currently operated by Waterbury Hospital on the hospital campus.

Following the Asset Purchase, there will be no change in operations or services offered by Waterbury Hospital as a result of GWHN transferring its interests to PMH. Waterbury Hospital will continue to offer the same level of care to the same communities that are served by Waterbury Hospital. The Applicants do not anticipate any changes to the patient population or payor mix at Waterbury Hospital or any adverse impact on the communities' access to CT services.

a. Provide the manufacturer, model and number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Equipment	Manufacturer	Model	Slices/Strength	Use
CT	GE	HiSpeed Cti	Single Slice	Replaced June 2015
CT	Toshiba	Aquillon	64 Slice	
CT	Prime CT	Prime CT	80 Slice	Effective June 2015

b. List each of the Applicant's sites and the imaging modalities currently offered by location.

Waterbury Hospital is located at 64 Robbins Street, Waterbury, Connecticut. Imaging services provided at this location include:

- CT scans;
- Digital mammography;
- Ultrasound;
- Diagnostic x-ray;

- Interventional radiology;
- MRI (through Greater Waterbury Imaging Center); and
- Nuclear medicine.

2. Clear Public Need

a. Complete Table A for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

TABLE A
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Service*	Days/Hours of Operation **	Utilization***
Waterbury Hospital 64 Robbins Street Waterbury, Connecticut	CT (Single Slice until June 2015; 80 slice effective June 2015)	7 days a week/24 hours a day	19,213 combined[1] for FY 2015
Waterbury Hospital 64 Robbins Street Waterbury, Connecticut	CT (64 Slice)	7 days a week/24 hours a day	

*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
***Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

b. Provide the rationale for locating the proposed equipment at the proposed site;

The Applicants are proposing to transfer ownership of the existing CT scanners at the 64 Robbins Street location to a subsidiary of PMH that will continue the operations of Waterbury Hospital and its on-campus CT scanner services as part of part of the proposed Asset Purchase. Following the Asset Purchase, no change in the location of CT scanners is anticipated as a result of GWHN transferring its interests to PMH.

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 B, report the units of service by piece of equipment, and in Table C, 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).

[1] Please note that GWHN does not keep separate utili□ation records for each of its scanners.

TABLE B

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT[2]

Total CT Machines

Equipment***	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Inpatient	6,307	5,911	6,581	6,484	6,484	6,484	6,484
Outpatient	2,728	4,301	4,521	4,808	4,808	4,808	4,808
ED	6,327	7,111	7,802	7,921	7,921	7,921	7,921
Total	**15,407**	**17,323**	**18,904**	**19,213**	**19,213**	**19,213**	**19,213**

*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.
****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 C

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY TYPE OF SCAN/EXAM

****PLEASE SEE ATTACHED EXHIBIT TABLE C FOR INFORMATION REQUESTED.**

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Volume projections by scanner and scan type assumes that utilization will remain constant at FY 2015 levels through FY 2018.

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

Increases and decreases are based on normal volume fluctuation.

d. Provide a breakdown, by town, of the volumes provided in Table C for the most recently completed FY.

[2] Please note that GWHN does not keep separate utili□ation records by e□uipment unit.

TABLE D

UTILIZATION BY TOWN

****PLEASE SEE ATTACHED EXHIBIT TABLE D FOR INFORMATION REQUESTED. PLEASE NOTE THAT GWHN DOES NOT KEEP SEPARATE UTILIZATION RECORDS BY EQUIPMENT UNIT.**

Equipment*	Town	Utilization FY 2015
CT		

*Identify each scanner separately and add lines as necessary. Also, break out inpatient/outpatient/ED volumes if applicable and include equipment strength (e.g., slices, tesla strength), whether the unit is open or closed (for MRI).
**Fill in year

EXHIBIT TABLE

Waterbury Hospital

CPT CODE & DESCRIPTION	FY 2012	FY 2013	FY 2014	FY 2015
70450 - CT HEAD/BRAIN W/O DYE	5437	5736	6091	5736
70460 - CT HEAD/BRAIN W/DYE	59	31	33	32
70470 - CT HEAD/BRAIN W/O & W/DYE	59	42	39	33
70480 - CT ORBIT/EAR/FOSSA W/O DYE	37	54	74	47
70481 - CT ORBIT/EAR/FOSSA W/DYE	38	25	21	29
70482 - CT ORBIT/EAR/FOSSA W/O&W/DYE	9	7	5	8
70486 - CT MAXILLOFACIAL W/O DYE	400	559	625	609
70487 - CT MAXILLOFACIAL W/DYE	19	15	19	23
70488 - CT MAXILLOFACIAL W/O & W/DYE		1		1
70490 - CT SOFT TISSUE NECK W/O DYE	30	49	49	60
70491 - CT SOFT TISSUE NECK W/DYE	139	170	150	169
70492 - CT SFT TSUE NCK W/O & W/DYE	1	3	2	1
70496 - CT ANGIOGRAPHY HEAD	38	66	153	140
70498 - CT ANGIOGRAPHY NECK	56	81	159	145
71250 - CT THORAX W/O DYE	793	997	1086	1196
71260 - CT THORAX W/DYE	1639	1815	1987	2085
71270 - CT THORAX W/O & W/DYE		8		44
71275 - CT ANGIOGRAPHY CHEST	8	12	30	21
72125 - CT NECK SPINE W/O DYE	756	1059	1264	1304
72126 - CT NECK SPINE W/DYE	3	3	3	4
72127 - CT NECK SPINE W/O & W/DYE	1		1	1
72128 - CT CHEST SPINE W/O DYE	34	36	42	38
72129 - CT CHEST SPINE W/DYE	5	2	2	2
72131 - CT LUMBAR SPINE W/O DYE	127	172	206	239
72132 - CT LUMBAR SPINE W/DYE	11	8	5	8
72133 - CT LUMBAR SPINE W/O & W/DYE	1			
72191 - CT ANGIOGRAPH PELV W/O&W/DYE	10	5	11	3
72192 - CT PELVIS W/O DYE	61	78	80	97
72193 - CT PELVIS W/DYE	34	29	35	36
72194 - CT PELVIS W/O & W/DYE	0	3	4	8
73200 - CT UPPER EXTREMITY W/O DYE	49	56	50	70
73201 - CT UPPER EXTREMITY W/DYE	3	1	9	13
73206 - CT ANGIO UPR EXTRM W/O&W/DYE	3	2	3	1
73700 - CT LOWER EXTREMITY W/O DYE	131	125	170	174
73701 - CT LOWER EXTREMITY W/DYE	13	15	18	22
73706 - CT ANGIO LWR EXTR W/O&W/DYE	4	3	4	3
74150 - CT ABDOMEN W/O DYE	71	79	83	60
74160 - CT ABDOMEN W/DYE	188	194	165	186
74170 - CT ABDOMEN W/O & W/DYE	10	15	9	16
74174 - CT ANGIO ABD&PELV W/O&W/DYE	6	23	25	25
74175 - CT ANGIO ABDOM W/O & W/DYE	7	7	11	7
74176 - CT ABD & PELVIS W/O CONTRAST	3001	2791	3433	3407
74177 - CT ABD & PELV W/CONTRAST	1785	2518	2402	2731
74178 - CT ABD & PELV 1/> REGNS	142	204	157	158
74261 - CT COLONOGRAPHY DX	2	1	1	4
74263 - CT COLONOGRAPHY SCREENING	1		3	2
75571 - CT HRT W/O DYE W/CA TEST	1			
75574 - CT ANGIO HRT W/3D IMAGE	5			
75635 - CT ANGIO ABDOMINAL ARTERIES	23	38	35	51
77012 - CT SCAN FOR NEEDLE BIOPSY	133	143	150	147
77013 - CT GUIDE FOR TISSUE ABLATION	2			0
77014 - CT SCAN FOR THERAPY GUIDE	22	42	0	17
Grand Total	**15407**	**17323**	**18904**	**19213**

EXHIBIT TABLE

DATA BASE	2015
PT-ST	CT
TOWN	**# OF CT SCANS**
Ansonia	20
Avon	2
BANTAM	8
BEACON FALLS	158
BETHANY	37
Bethel	13
BETHELHEM	3
BETHLEHEM	166
Bridgeport	37
BRIDGEWATER	6
Bristol	85
Brookfield Center	11
BURLINGTON	6
Canton	1
CHESHIRE	173
Cos Cob	1
Danbury	38
Deep River	1
Derby	13
Durham	1
East Haddam	1
East Hartford	1
EAST HAVEN	10
Easton	8
ENFIELD	2
Fairfield	2
FARMINGTON	1
Forestville	1
Glastonbury	11
Goshen	23
Greenwich	5
Guilford	1
Haddam Neck	1
HAMDEN	3
Hartford	18
HARWINGTON	1
HARWINTON	18
HUNTINGTON	1
Kenington	1
Killingworth	1
LAKESIDE	5
Litchfield	42
Manchester	2
MANSFIELD	1

TOWN	# OF CT SCANS
Marion	3
Meriden	42
MIDDLEBURY	533
Middlefield	2
Middletown	5
Milford	12
MILLDALE	1
Monroe	13
Morris	54
NAUGATUCK	1,999
NEW BRITAIN	14
New Canaan	2
New Hartford	5
New Haven	35
New London	1
NEW MILFORD	17
Newington	4
Newtown	13
Norfolk	6
North Franklin	4
North Haven	1
NORTHFIELD	42
Norwalk	7
NORWICH	1
OAKVILLE	819
Orange	6
Oxford	145
Plainville	17
Plantsville	24
Plymouth	103
Prospect	419
Redding	2
Ridgefield	4
Rockfall	2
ROCKVILLE	1
Rocky Hill	8
ROXBURY	10
Sandy Hook	7
Seymour	67
Shelton	15
Sherman	1
SimSbury	1
SOUTH BRITAIN	1
South Norwalk	5
SOUTHBURY	930
SOUTHINGTON	76

TOWN	# OF CT SCANS
Stamford	4
Stratford	12
Talcott Village	6
Terryville	141
THOMASTON	558
Tolland	1
TORRINGTON	222
Trumbull	1
Unionville	3
VERNON	1
WALLINGFORD	3
WARREN	4
Washington	2
Waterbury	9,153
WATERTOWN	1,321
West Hartford	8
West Haven	16
West Redding	1
Wethersfield	1
Whitneyville	2
WINCHESTER CENTER	1
Windsor	2
Winsted	34
WOLCOTT	537
Woodbridge	9
WOODBURY	514
WOOODBURY	1
Yalesville	12
Grand Total	18,989
Outside of Connecticut	224
	19,213

EXHIBIT Q22-1

2013 WATERBURY HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT

GREATER WATERBURY
HEALTH IMPROVEMENT PARTNERSHIP

Community Health Needs Assessment

Final Summary Report

September 2013

HOLLERAN

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EXECUTIVE SUMMARY

The Greater Waterbury Health Improvement Partnership led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2012. The partnership consisted of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled the Greater Waterbury Health Improvement Partnership to take an in-depth look at its greater community. The findings from the assessment were utilized by the partnership to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The Greater Waterbury Health Improvement Partnership is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Statistical Data Profile of Waterbury, Connecticut and surrounding cities
- Household Telephone Survey with 1,100 community residents
- Focus Group Discussions with 24 health care providers and 33 community residents
- Key Informant Interviews with 205 community leaders and partners
- Prioritization Session
- Hospital Implementation Plans
- Community Health Improvement Plan (CHIP)

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the Greater Waterbury Health Improvement Partnership plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Documentation

A final report of the CHNA was made public in September 2013 and can be found on the partner's websites. Hospital Implementation Plans, as well as a Community Health Improvement Plan (CHIP), were developed and adopted by each appropriate authority in September 2013.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Background

The Greater Waterbury Health Improvement Partnership is made up of a group of not-for-profit organizations serving the residents of Waterbury, Connecticut and surrounding communities. The Greater Waterbury Health Improvement Partnership defined their current service area as the City of Waterbury and the surrounding communities served by Saint Mary's Hospital and Waterbury Hospital. The area encompasses southwest Connecticut and is relatively large with a population of approximately 313,000 residents. The geographic area was defined by primary service area (PSA) and secondary service area (SSA). The PSA is the area that the partnership predominantly serves and the hospitals main catchment area. It comprises all of Waterbury and has a population of approximately 110,000 residents. The SSA includes portions of the surrounding communities served by the two hospitals and has a population of approximately 203,000 residents. The conclusions drawn from the various research components focus on the primary service area, the town of Waterbury, Connecticut.

CHNA Partners

- The City of Waterbury
- Connecticut Community Foundation
- Saint Mary's Hospital
- StayWell Health Center
- Waterbury Department of Public Health
- Waterbury Hospital
- The United Way

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

Quantitative Data:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates and other health statistics for Waterbury, Connecticut and surrounding cities was compiled.

- A Household Telephone Survey was conducted with 1,100 randomly-selected community residents. The survey was modeled after the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) which assesses health

status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

Qualitative Data:

- Six Focus Groups were held with 24 health care providers and 33 community residents in February 2013.

- Key Informant Interviews were conducted with 205 community leaders and partners between February and April 2013.

Research Partner

The Greater Waterbury Health Improvement Partnership contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data
- Conducted, analyzed, and interpreted data from the household telephone survey
- Conducted focus groups with community members
- Conducted key informant interviews with community leaders and partners
- Facilitated a Prioritization and Planning Session
- Prepared all reports

Community Representation

Community engagement and feedback were an integral part of the CHNA process. The Greater Waterbury Health Improvement Partnership sought community input through focus groups with health care providers and community members, key informant interviews with community leaders and partners, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

It should be noted that the availability and time lag of secondary data may present some research limitations. Additionally, language barriers, timeline, and other restrictions may have impacted the ability to survey all community stakeholders. The Greater Waterbury Health Improvement Partnership sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, the Greater Waterbury Health Improvement Partnership prioritized community health issues and developed an implementation plan to address prioritized community needs.

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to create a Secondary Data Profile. Secondary data is comprised of data obtained from existing resources and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health indicators, among other data points. The data was gathered and integrated into a graphical report to portray the current health and socio-economic status of residents in the Greater Waterbury Health Improvement Partnership service area.

Secondary data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Waterbury Department of Health, and the Connecticut Department of Public Health. Data sources are listed throughout the report and a full reference list is included in Appendix A. The data represents a point in time study using the most recent data possible. When available, state and national comparisons are provided as benchmarks.

The profile details data covering the following areas:

- Demographic/Socioeconomic Statistics
- Mortality Statistics
- Maternal & Child Health Statistics
- Sexually Transmitted Illness & Communicable Disease Statistics
- Mental Health Statistics
- Cancer Statistics
- Environmental Health Statistics
- Health Care Access Statistics
- Crime Statistics

Secondary Data Profile Key Findings

This section serves as a summary of the key takeaways from the secondary data profile. A full report of the findings is available through the Greater Waterbury Health Improvement Partnership.

Demographic Statistics

According to U.S. Census Bureau estimates (2009-2011), the total population in Waterbury, Connecticut is 110,075, a decline of 2.55% since 2000. The majority of residents identify as White (58.2%), indicating a less diverse population when compared to peer cities, but a more diverse population when compared to all of Connecticut. Approximately 19% of residents identify as Black/African American and 30.1% identify as Hispanic or Latino. The primary spoken language is English, but 31.6% of residents speak a language other than English at home. The median age in Waterbury is 35.2, which denotes a younger population when compared to Connecticut, but an older population when compared to most peer cities (U.S. Census Bureau, 2012).

Table 1. Overall Population (2009-2012)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
White	78.6%	58.2%	32.2%	46.7%	48.6%	59.6%
Black/African American	9.8%	19.4%	37.2%	34.4%	34.5%	14.8%
Asian	3.8%	1.7%	2.5%	4.9%	3.6%	8.05%
Two or more races	2.3%	5.6%	4.0%	2.9%	1.9%	1.7%
Hispanic or Latino (of any race)[b]	13.0%	30.1%	42.4%	26.3%	36.7%	24.4%

Source: U.S. Census Bureau, 2012

[a] Percentages may equal more than 100% as individuals may report more than one race

[b] Hispanic/Latino residents can be of any race, for example, White Hispanic

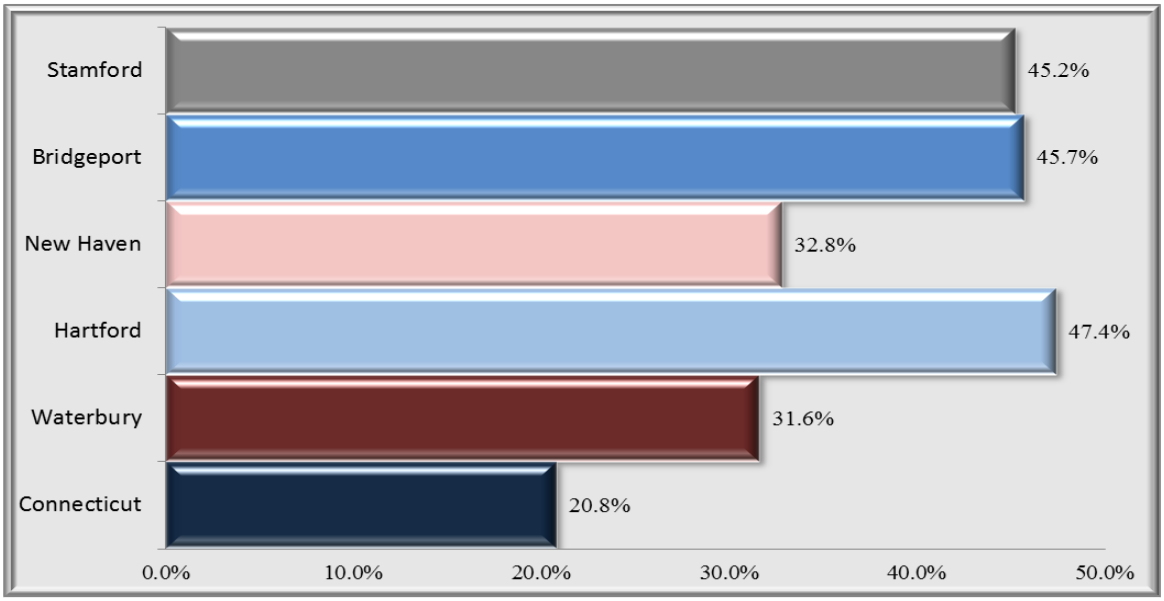


Figure 1. Percentage of population speaking a language other than English, 2009-2011
Source: U.S. Census Bureau, 2012

Waterbury is comprised primarily of family households (63.2%), which are defined as more than one person living together, either as relations or as a married couple. These households and nonfamily households are less likely to live in owner-occupied units (49.6%) compared to Connecticut (68.9%), but more likely to live in owner-occupied units compared to most peer cities. The median value for owner-occupied units is $164,000, which is lower than the median value across the state ($293,100) and all peer cities (U.S. Census Bureau, 2012).

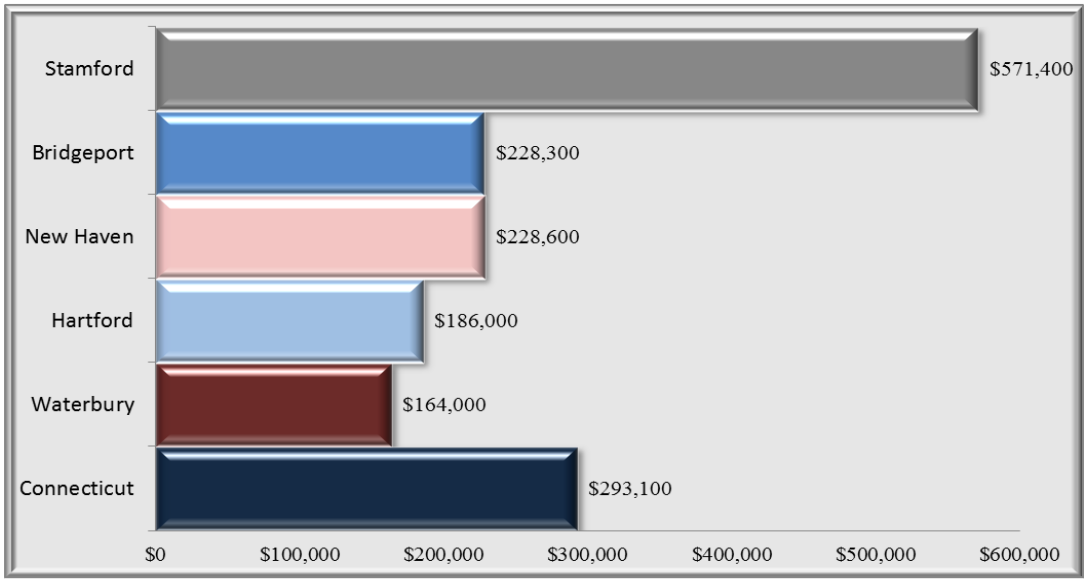


Figure 2. Median value for owner-occupied unit, 2009-2011
Source: U.S. Census Bureau, 2012

Approximately 40% of Waterbury residents aged 15 years and over have never been married. This is greater than the percentage across Connecticut (31.8%), but lower than the percentage across most peer cities. Among those residents who have been married, a higher percentage are divorced (11.6%) compared to Connecticut (10.2%) and all peer cities (U.S. Census Bureau, 2012).

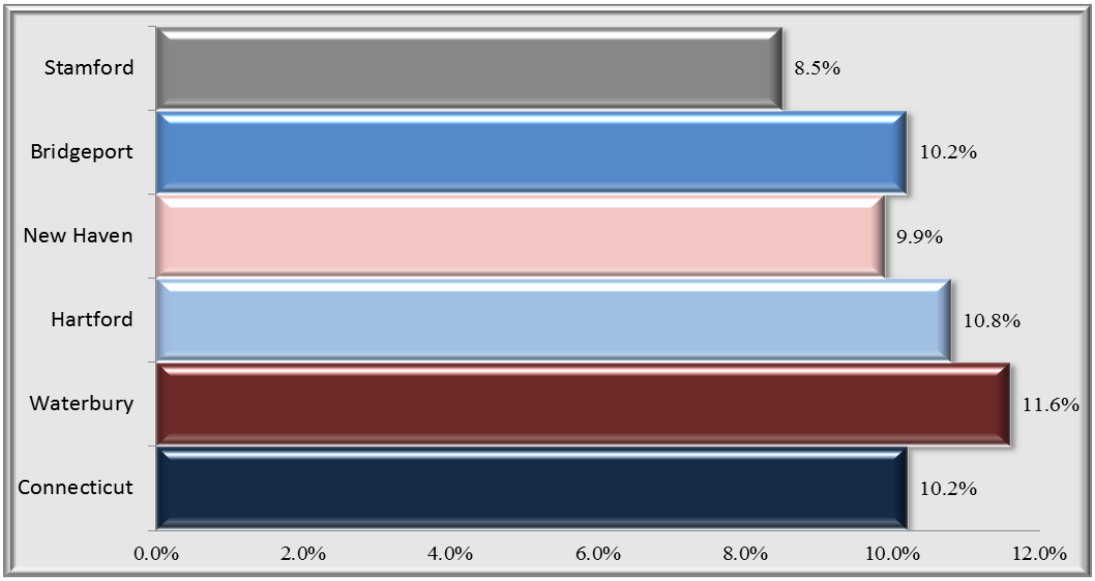


Figure 3. Divorce Rate, 2009-2011
Source: U.S. Census Bureau, 2012

The median income for households and families across Waterbury ($41,499 and $49,059 respectively) is lower than across all of Connecticut ($69,243; $86,395). However, it is higher when compared to most peer cities. The same trend is true of the median income for workers. The percentage of families and individuals living in poverty in the past 12 months is higher in Waterbury than in all of Connecticut (U.S. Census Bureau, 2012). More residents in Waterbury are also enrolled in social assistance programs like Temporary Family Assistance and Medicaid when compared to Connecticut and most peer cities. Between the years 2011 and 2012, 28.2% of residents were enrolled in Temporary Family Assistance and 38.1% were enrolled in Medicaid. Medicaid enrollment has been on the rise across all of Connecticut and its cities since 2006 (Connecticut Department of Social Services, n.d.).

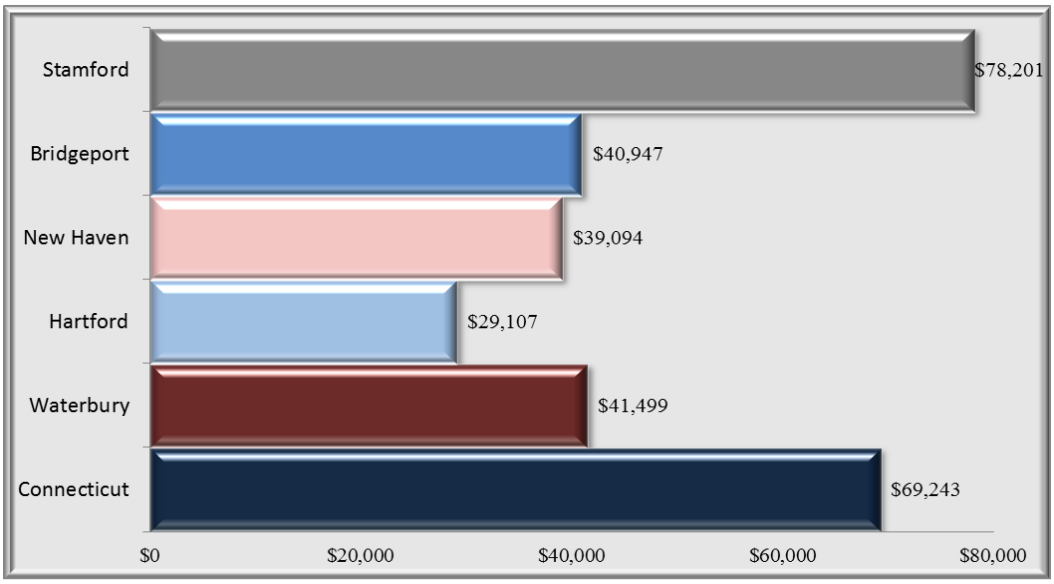


Figure 4. Median household income, 2009-2011
Source: U.S. Census Bureau, 2012

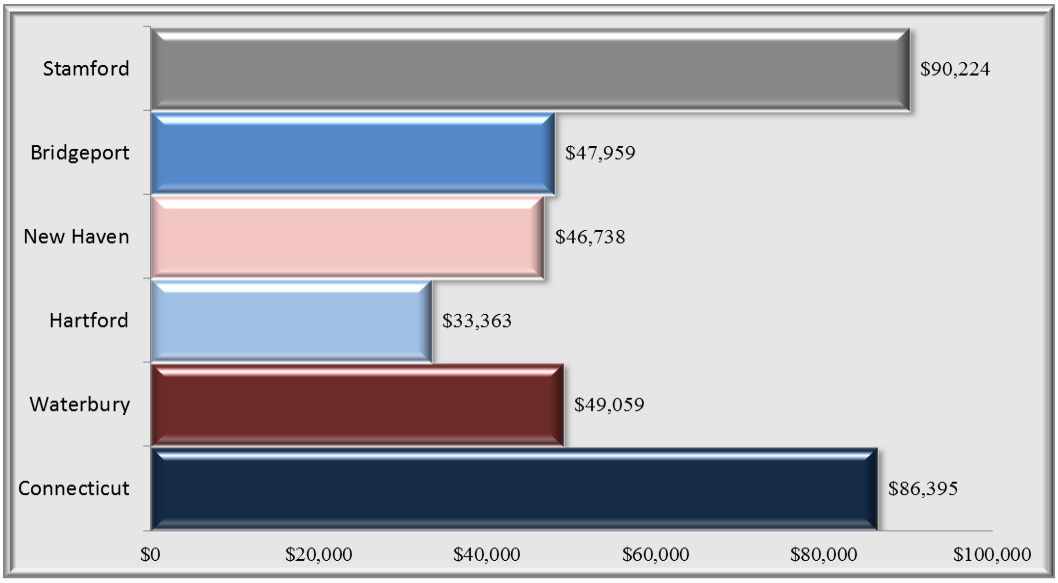


Figure 5. Median family income, 2009-2011
Source: U.S. Census Bureau, 2012

Table 2. Poverty Status of Families and People in the Past 12 Months (2010)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Families	6.7%	17.1%	29.9%	20.8%	18.0%	7.5%
With related children < 18 years	10.8%	26.3%	39.3%	30.0%	25.3%	11.6%
With related children < 5 years	12.5%	22.4%	46.1%	21.3%	20.6%	12.7%
Married couple families	2.3%	5.6%	9.3%	7.4%	7.3%	3.4%
With related children < 18 years	3.1%	7.7%	12.1%	11.2%	10.7%	4.5%
With related children < 5 years	3.4%	7.5%	11.3%	9.2%	6.0%	3.8%
Families with female householder, no husband present	22.9%	35.5%	44.5%	36.9%	34.1%	22.1%
With related children < 18 years	30.8%	44.3%	51.6%	44.9%	40.8%	30.4%
With related children < 18 years	40.1%	47.7%	60.8%	42.7%	41.1%	35.8%
All people	9.5%	20.6%	32.9%	26.3%	21.9%	11.0%

Source: U.S. Census Bureau, ACS estimates

According to the U.S. Census Bureau (2012), the unemployment rate in Waterbury is 12.7%. This rate is higher than the unemployment rate across Connecticut (8.5%). It is favorable or comparable to peer cities. Of the residents who are employed, the majority work in management, business, science, and arts and are private wage and salary workers. A notable percentage of residents are also employed in a service occupation.

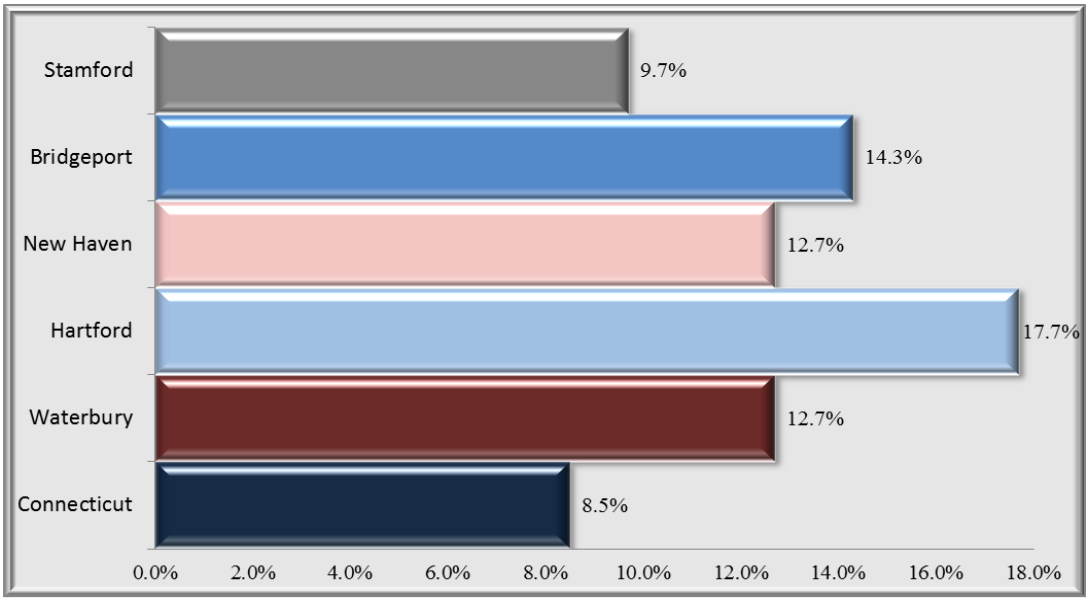


Figure 6. Unemployment rate for civilian labor force, 2009-2011
Source: U.S. Census Bureau, 2012

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. High school and higher education graduation rates are lower in Waterbury (78.7% and 17.2% respectively) than in Connecticut (88.6% and 35.7% respectively) and comparable to peer cities (U.S. Census Bureau, 2012).

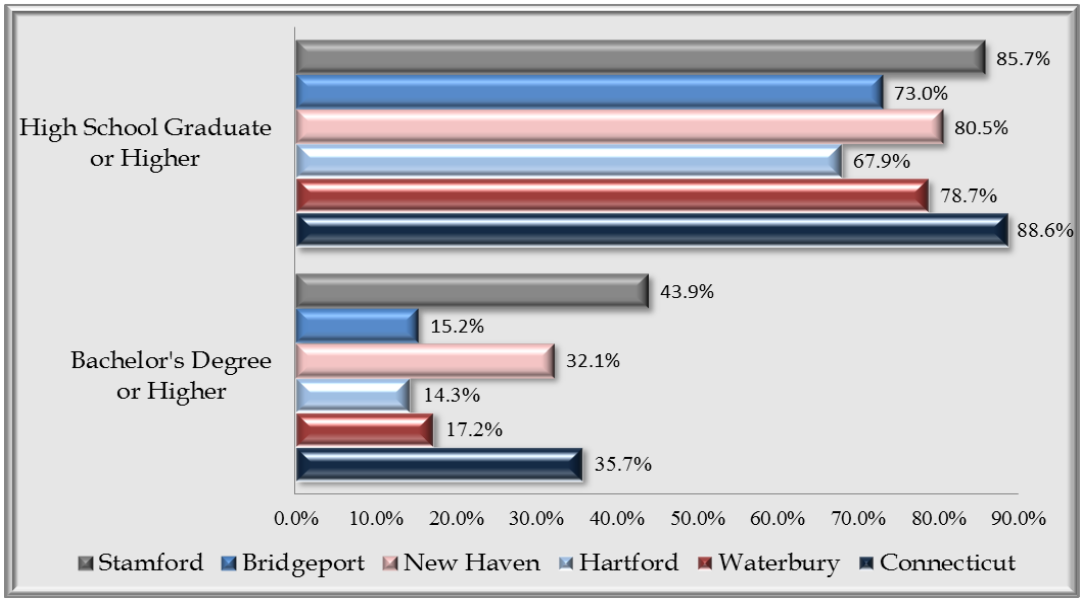


Figure 7. Educational attainment, 2009-2011
Source: U.S. Census Bureau, 2012

Health Status Indicators

Mortality Rates

The overall crude mortality rate for Waterbury, Connecticut is 9.2 per 1,000. This is higher than the mortality rate for Connecticut (8.1 per 1,000) and peer cities. A contributing factor to the higher overall mortality rate in Waterbury compared to peer cities may be its slightly older population. However, this does not apply when comparing to all of Connecticut as the state has a higher median age (Connecticut Department of Public Health, 2011).

The graphs below detail the age-adjust deaths rates per 100,000 for three of the leading causes of death in Waterbury. For all causes, Waterbury has a higher death rate than Connecticut. For chronic lower respiratory disease, Waterbury has a higher death rate (37.2) than Connecticut and all peer cities. Death rates due to heart disease and cancer in Waterbury are comparable to peer cities, but are still of concern as the top two leading causes of death (Connecticut Department of Public Health, 2011).

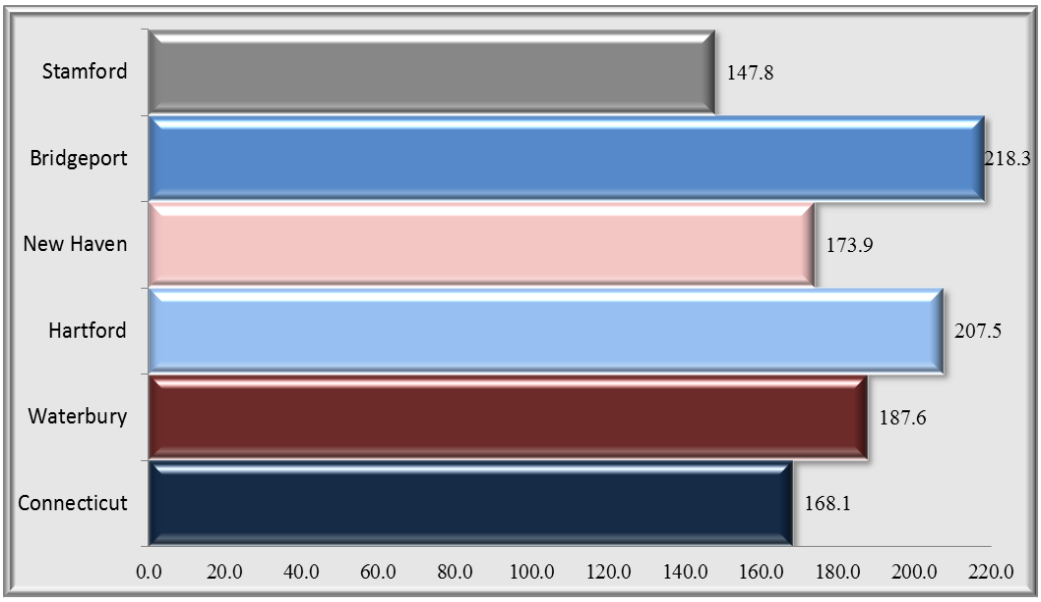


Figure 8. Deaths due to diseases of the heart per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

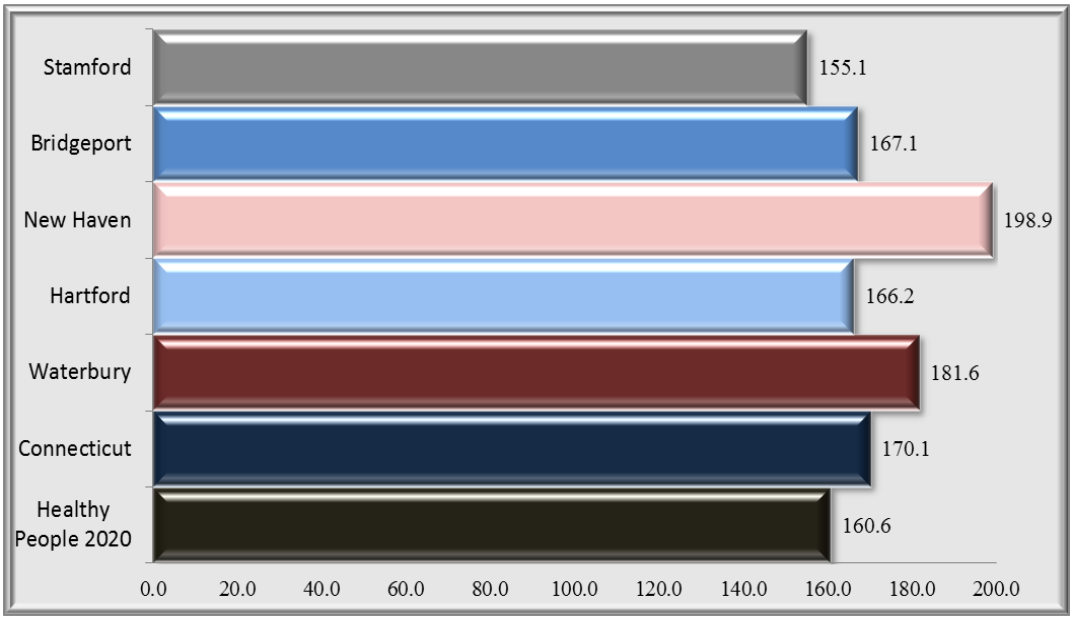


Figure 9. Deaths due to malignant neoplasms (cancer) per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011; Healthy People 2020, 2012;
Connecticut Department of Public Health, n.d.

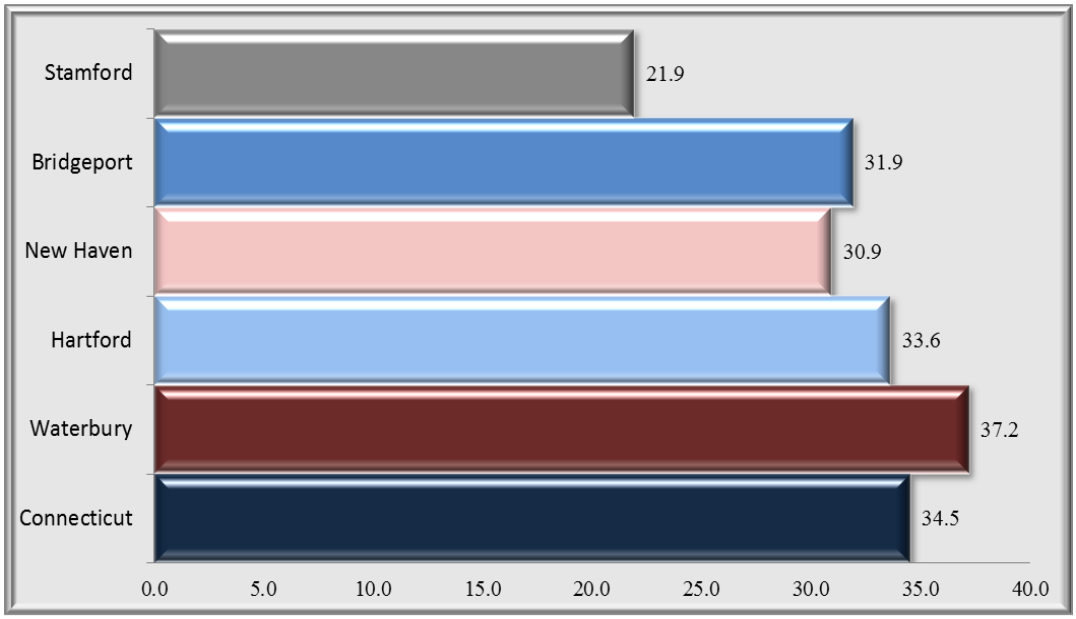


Figure 10. Deaths due to chronic lower respiratory disease per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

Maternal & Infant Health

The birth rate per 1,000 in Waterbury (15.7) is higher when compared to Connecticut (11.0), but similar to or lower than peer cities. Of the births that occur, 4.9% are to mothers less than 18 years of age and 14.5% are to mothers less than 20 years of age. These percentages are higher than what is seen across Connecticut (2.0% and 6.8% respectively) and all peer cities, excepting Hartford. The majority of teenage births are to mothers of Black and/or Hispanic race/ethnicity. Overall, the findings for teenage birth for the most recent year of data are negative, but births to teenagers less than 18 years of age have been trending downwards since 2005 (Connecticut Department of Public Health, 2011).

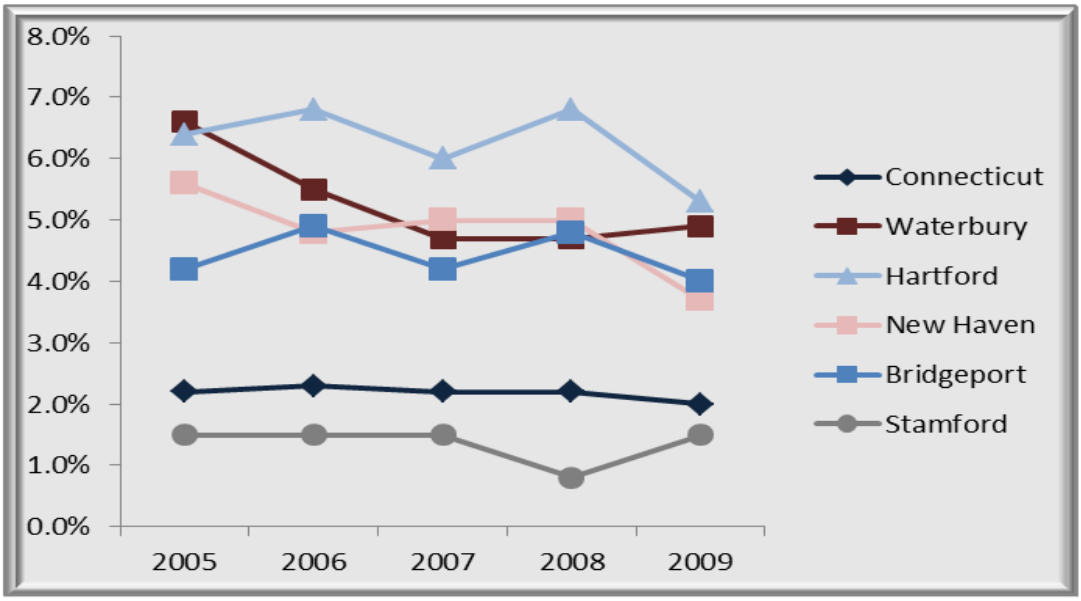


Figure 11. Births to teenagers less than 18 years, 2005 - 2009
Source: Connecticut Department of Public Health, 2007 - 2011

A total of 16 infant deaths occurred in Waterbury for a rate of 9.5 per 1,000 live births. This is higher when compared to Connecticut (5.6) and the Healthy People 2020 goal (6.0). The majority of infant deaths was among White infants (11 deaths, rate of 8.6) and occurred in the neonatal phase (within the first 27 days after birth). Seven Hispanic infant deaths also occurred in Waterbury for a rate of 10.4. This compares to a rate of 7.1 across all of Connecticut. In general, infant mortality has trended upwards in Waterbury since 2005 (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Related to infant mortality is birth weight. The percentage of infants born with low birth weight in Waterbury (10.0%) is higher when compared to Connecticut (8.1%), the Healthy People 2020 goal (7.8%), and every peer city except Hartford (10.5%). In particular, the percentage of Black infants born with low birth weight (14.6%) and very low birth weight (4.1%) is notably higher compared to Connecticut (12.0%; 3.2%) and all peer cities. Low birth weight has been on the rise in Waterbury since 2005, particularly for Black infants (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Despite primarily negative findings related to teenage birth, infant mortality, and birth weight, Waterbury mothers are more likely to receive adequate and intensive prenatal care than mothers across Connecticut. This is true for mothers of White, Black, and Hispanic race/ethnicity. Mothers receiving late or no prenatal care has been on the decline in Waterbury since 2005 (Connecticut Department of Public Health, 2011).

Sexually Transmitted Illnesses

Sexually transmitted illness rates per 100,000 are notably higher in Waterbury than in Connecticut, particularly for chlamydia and gonorrhea. The chlamydia rate is 720.5 in Waterbury compared to 344.9 in Connecticut and the gonorrhea rate is 225.9 in Waterbury compared to 72.6 in Connecticut. The Waterbury rates are more favorable compared to peer cities. The chlamydia rate alone is as high as 1,220.3 in New Haven and 1,513.8 in Hartford (Connecticut Department of Public Health, n.d.). The following chart illustrates this difference.

Table 3. Sexually Transmitted Illness Cases per 100,000 (2009, 2010)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
HIV	11.4	17.2	54.5	31.6	33.3	11.4
Gonorrhea	72.6	225.9	403.0	363.3	239.6	37.2
Chlamydia	344.9	720.5	1,513.8	1,220.3	863.8	268.5
Primary/Secondary Syphilis	1.8	1.9	6.4	3.2	4.4	2.5

Sources: Connecticut Department of Public Health, n.d.

[a] All statistics represent 2009 data with the exception of HIV, which represents 2010 data

Mental Health Statistics

The suicide rate is considered to be an indicator of the mental health status of an area. The suicide rate per 100,000 in Waterbury is 8.6, which meets the Healthy People 2020 goal of 10.2, but is higher than Connecticut (7.8) and all peer cities (5.5 – 8.4). The suicide rate is a negative finding, but it should not be considered an all-encompassing indication of the mental health status of Waterbury. Additional indicators from the household telephone survey, focus groups, and key informant interviews should be considered for a more comprehensive understanding (Connecticut Department of Public Health, n.d. & Healthy People 2020, 2012).

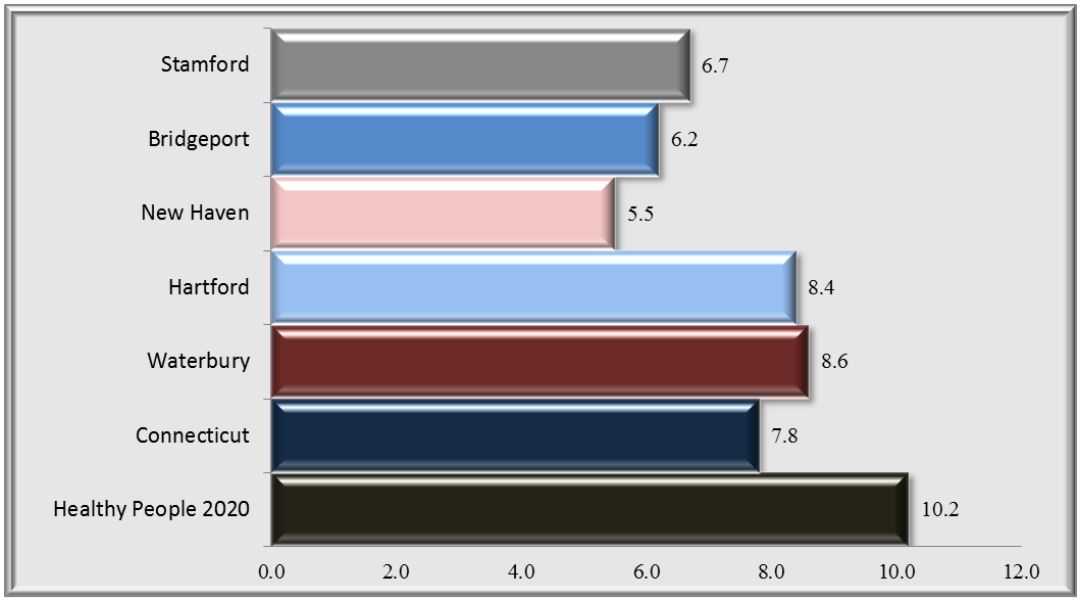


Figure 12. Suicide rates per 100,000, 2005 - 2009
Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Cancer Statistics

Cancer affects Waterbury residents at a rate of 484.3 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 484.3 is similar to or lower than that of Connecticut and peer cities. However, lung cancer disproportionately affects Waterbury residents at a rate of 81.2 compared to 74.3 across Connecticut and a range of 45.0 – 67.5 across all peer cities (Connecticut Department of Public Health, n.d.). The following chart depicts incidence rates for all reported cancer types.

Table 4. Cancer Incidence by Site per 100,000 (2007)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	155.6[a]	134.8 [a]	83.7 [a]	118.9 [a]	107.8 [a]	155.8 [a]
Colorectal	51.3	51.3	33.7	37.9	43.2	65.0
Lung	74.3	81.2	45.0	55.7	64.4	67.5
Prostate	173.3[a]	76.2 [a]	119.5 [a]	116.8 [a]	128.6 [a]	178.8 [a]
All sites	**561.6**	**484.3**	**335.6**	**445.4**	**443.3**	**534.3**

Source: Connecticut Department of Public Health, n.d.
[a]Rates based on 2010 population counts

In contrast to the overall cancer incidence rate, the overall cancer mortality rate is higher in Waterbury than in Connecticut and all but one peer city, New Haven. The mortality rate per 100,000 for all cancer types is 181.6 in Waterbury compared to 170.1 across Connecticut and a range of 155.1 – 167.1 across Bridgeport, Stamford, and Hartford. Lung cancer presents as an area of concern again as the mortality rate for this condition is notably higher in Waterbury

(53.5) compared to Connecticut (45.0), Healthy People 2020 (45.5), and all peer cities (36.5 – 44.1) (Connecticut Department of Public Health, n.d.).

Table 5. Cancer Mortality by Site per 100,000 (2005 - 2009)

	HP 2020	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	20.6	N/A	12.8	11.0	17.9	14.5	11.7
Colorectal	14.5	14.6	15.9	16.4	18.5	13.8	12.8
Lung	45.5	45.0	53.5	42.2	44.1	43.3	36.5
Prostate	21.2	N/A	7.7	8.9	11.8	7.2	9.1
Skin	N/A	2.6	N/A	N/A	N/A	N/A	N/A
All sites	160.6	170.1	181.6	166.2	198.9	167.1	155.1

Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Environmental Health Statistics

The environment that residents live, work, and play in can have a profound impact on their health. An indicator of the environmental health of an area is the prevalence of asthma. In Waterbury, the rate per 100,000 for emergency department visits due to asthma is 144.0 in adults 18 years and over and 197.3 in children under 18 years. This is notably higher than Connecticut's rates for adults and children (44.7 and 61.3 respectively) and most peer cities. Among adults in Waterbury, females, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma. Among children in Waterbury, males, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma (Connecticut Department of Public Health, 2009).

Table 6. Emergency Department Visits due to Asthma per 10,000 (2001 – 2005)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Population 18 +	44.7	144.0	182.8	108.8	126.7	41.5
Population <18	61.3	197.3	241.7	213.8	165.9	80.8

Source: Connecticut Department of Public Health, 2009

Another indicator of the environmental health of an area is the presence of food deserts, which are defined by Census tracts. Food deserts are areas that have little or no access to fully-stocked grocery stores that offer fresh, healthy, and affordable foods. In Waterbury, a number of census tracts have large populations living in food deserts. However, census tract 9009352400 is of particular concern. It has the highest percentage of residents living in a food desert across four out of the five reported categories (United States Department of Agriculture, 2010).

Table 7. Food Deserts by Census Tracts in Waterbury, Connecticut (2012)

	Population with low access to nutritious food sources	Population with low income and low access	Population 0-17 years with low access	Population 65+ years with low access	Population with no vehicle and low access
9009352400	100.0%	12.7%	31.6%	9.7%	16.4%
9009352300	21.3%	2.5%	5.2%	2.5%	3.4%
9009352200	55.1%	18.5%	24.2%	2.9%	14.2%
9009352100	33.7%	5.4%	9.5%	4.7%	3.6%
9009351800	57.7%	3.6%	10.8%	9.5%	3.7%
9009351500	45.9%	5.6%	11.7%	7.4%	7.0%
9009352800	33.4%	2.8%	11.4%	2.4%	4.3%

Source: United States Department of Agriculture, 2010

Secondary Data Profile Summary of Findings

The secondary data profile provided valuable context regarding how socioeconomic factors like income, education levels, and housing may influence local health outcomes. In Waterbury, the median income for households and families is higher; fewer residents live in poverty when compared to most peer cities. Residents are also less likely to rely on social assistance programs like Medicaid and State Administered General Assistance medical. In terms of health outcomes, Waterbury has lower rates of stroke mortality and sexually transmitted illness incidence. Waterbury has a number of strengths and assets, but it also has some areas to improve upon. In particular, Waterbury residents have more respiratory health issues and issues related to maternal and child health. In relation to respiratory health, residents are more likely to have visited an emergency department for asthma complications and to have died from lung cancer and chronic lower respiratory disease. Related to maternal and child health, the infant mortality rate is higher, infants are more likely to be born with low or very low births weight, and the number of teenage pregnancies is higher. Additional areas of concern in Waterbury are the suicide rate and food deserts, particularly in census tract 9009352400.

HOUSEHOLD TELEPHONE SURVEY OVERVIEW

Background

A statistical Household Telephone Survey was conducted based on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national initiative, conducted annually at the state level. The survey assesses self-reported health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

For the Waterbury study, trained interviewers conducted telephone interviews between May and June 2013 by trained interviewers. Participants were randomly selected for participation based on a statistically valid sampling frame that included landline and cell phone telephone numbers. Only respondents who were at least 18 years of age and lived in a private residence were included in the study. A total of 1,121 individuals who reside within specific Zip codes served by the Greater Waterbury Health Improvement Partnership were interviewed by telephone. Select participant demographics are included in Appendix C.

The customized survey tool consisted of approximately 100 factors selected from BRFSS tool. A few customized questions were added to gather information about health issues specific to the service area. Depending upon interviewees' responses, interviews ranged from approximately 15 to 30 minutes in length.

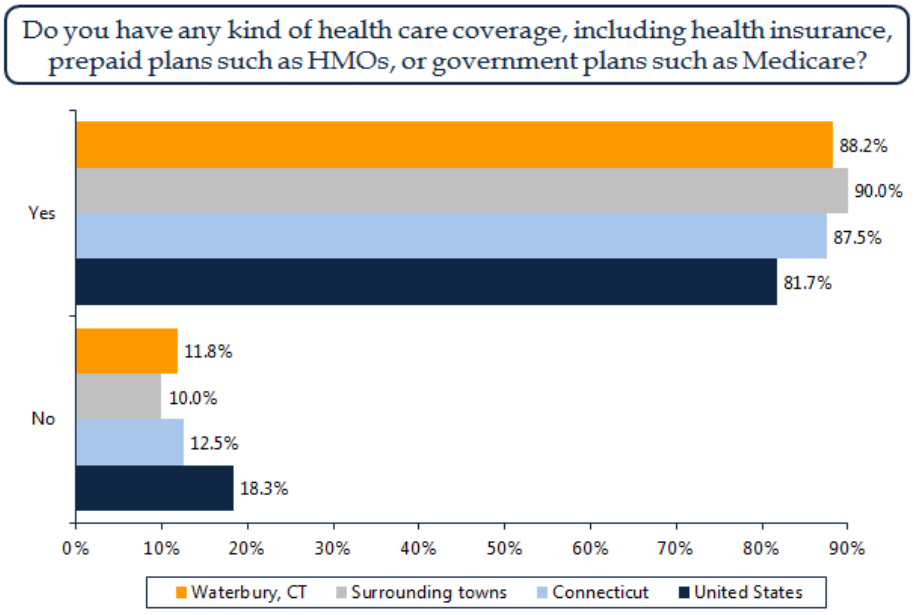
Statistical considerations for the study can be found in Appendix B. The following section provides a summary of the Household Telephone Survey results. A full report of the Household Telephone Survey results is available in a separate document.

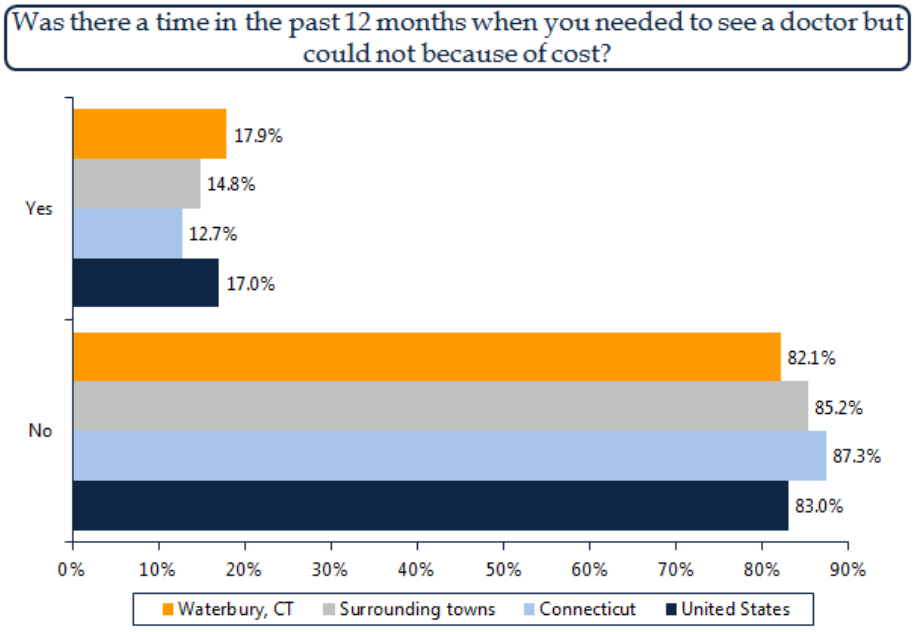
Household Telephone Survey Key Findings

The following section provides an overview of key findings from the Household Telephone Survey including highlights of important health indicators and health disparities.

Access to Health Care

Overall, residents of Waterbury are just as likely or more likely to have health care coverage (88.2%) and at least one person who they think of as their personal doctor or health care provider (84.1%) when compared to the state (87.5%; 85.2%) and the nation (81.7%; 78.0%). Local residents are also more likely to have received a routine checkup within the past year (76.6%) compared to the state (70.4%) and the nation (66.9%). Despite primarily positive findings regarding health insurance and access to primary care, residents of Waterbury still cite the cost of care as a barrier. Nearly 18% of respondents said that there was a time in the past 12 months when they needed to see a doctor but could not because of cost. This may be an indicator that out-of-pocket expenses that are not covered by insurance (e.g. copays) are preventing residents from seeking care when they need it.

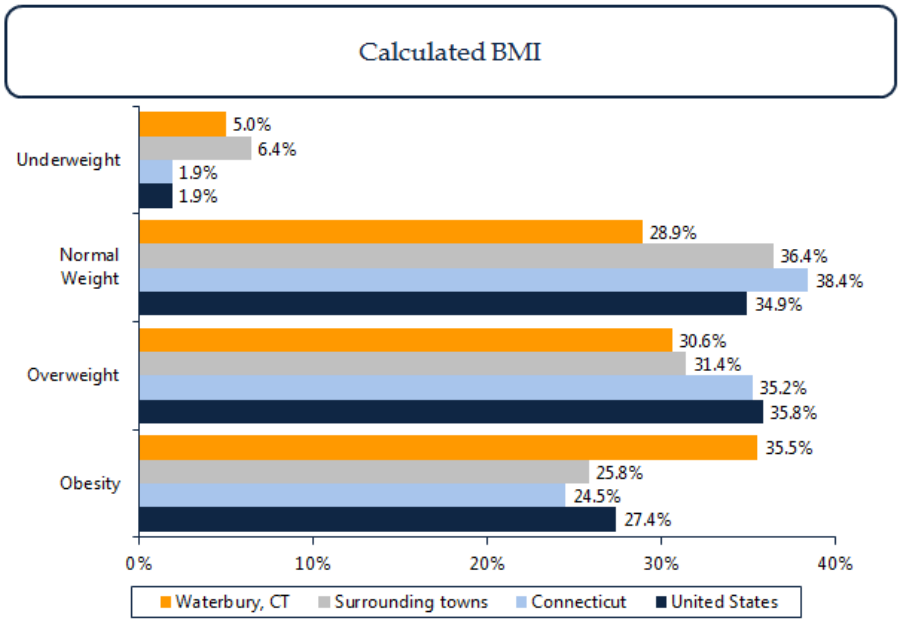




Health Risk Factors

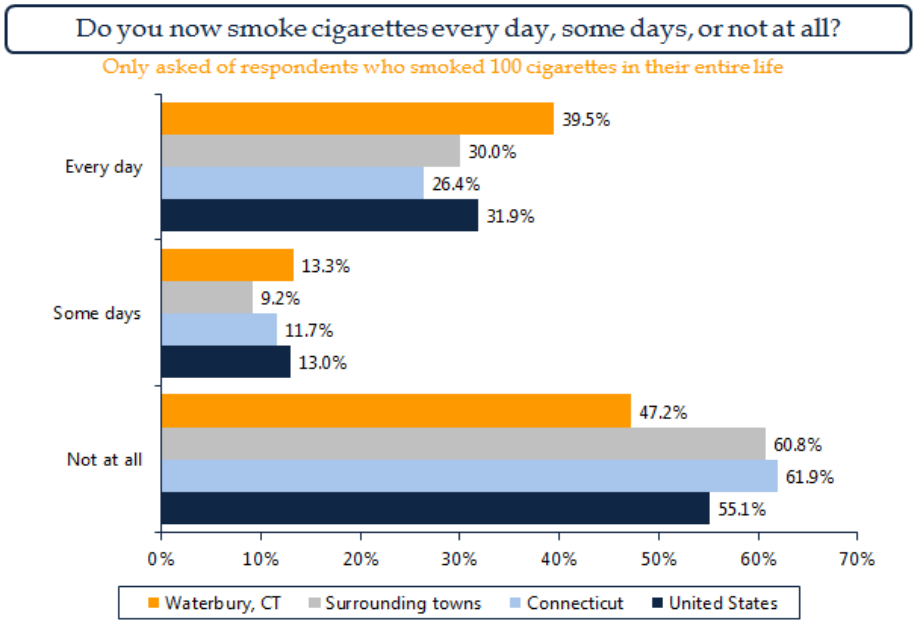
Obesity & Physical Activity

Obesity and its connection to serious medical conditions has become a national concern. In the latest BRFSS study, 63.2% of the nation and 59.7% of Connecticut was considered overweight or obese. Waterbury surpasses both with 66.1% of respondents considered overweight or obese and 35.5% considered obese. In addition, fewer respondents (68.9%) reported engaging in physical activity during the past month compared to the state (74.5%) and the nation (74.3%).

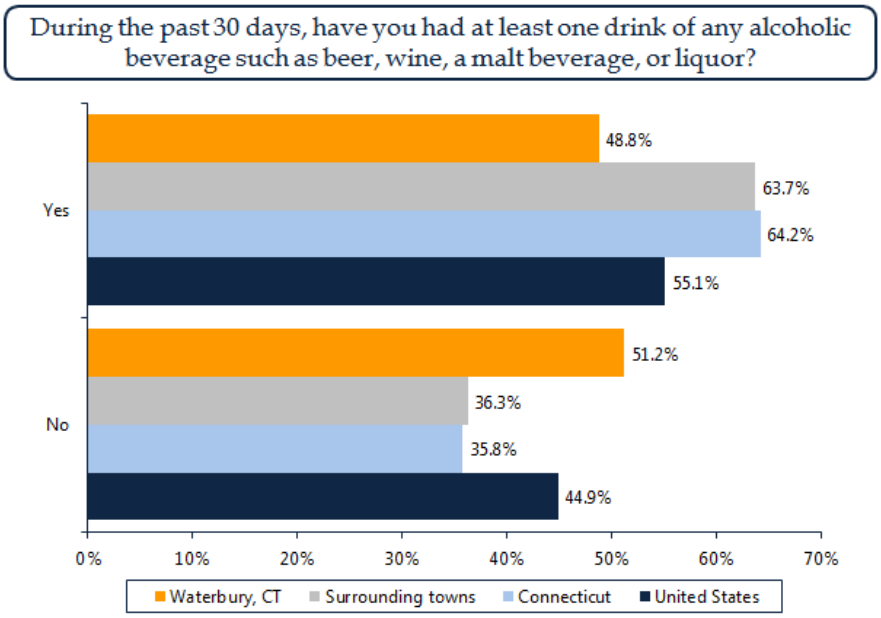


Tobacco & Alcohol Use

Tobacco use is a concern in Waterbury for both the proportion of residents who initiate smoking and the proportion who continue to smoke on a daily basis. More than half (51.1%) of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 45.0% across the state and 44.8% across the nation. In addition, more than half (52.8%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (38.1%) and the nation (44.9%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months.



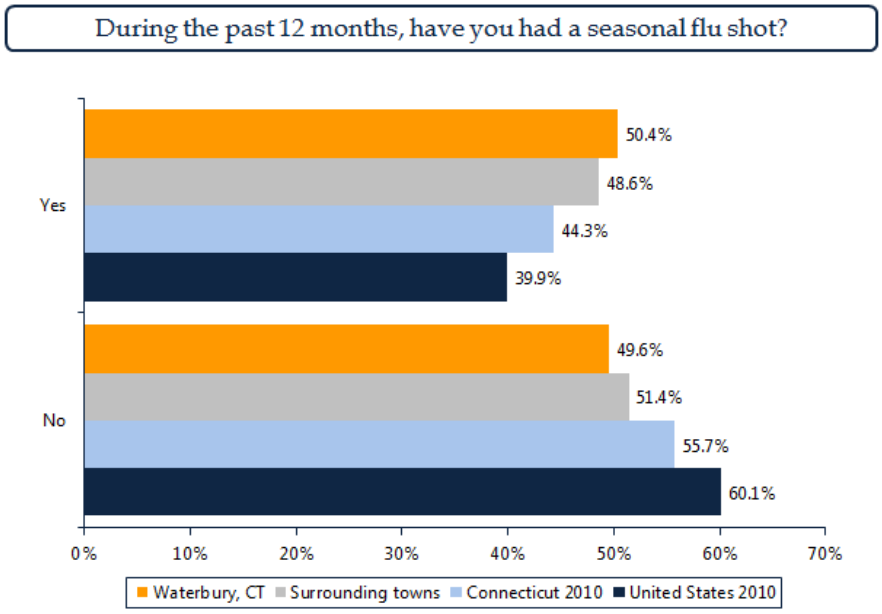
Alcohol use and abuse is not as prevalent. Only 48.8% of respondents had an alcoholic beverage during the past 30 days compared to 64.2% across Connecticut and 55.1% across the nation. Of the individuals who did consume alcohol, fewer did so on a daily basis or participated in binge drinking, and more than half had a maximum of one to two drinks at a time.



Preventive Health Practices

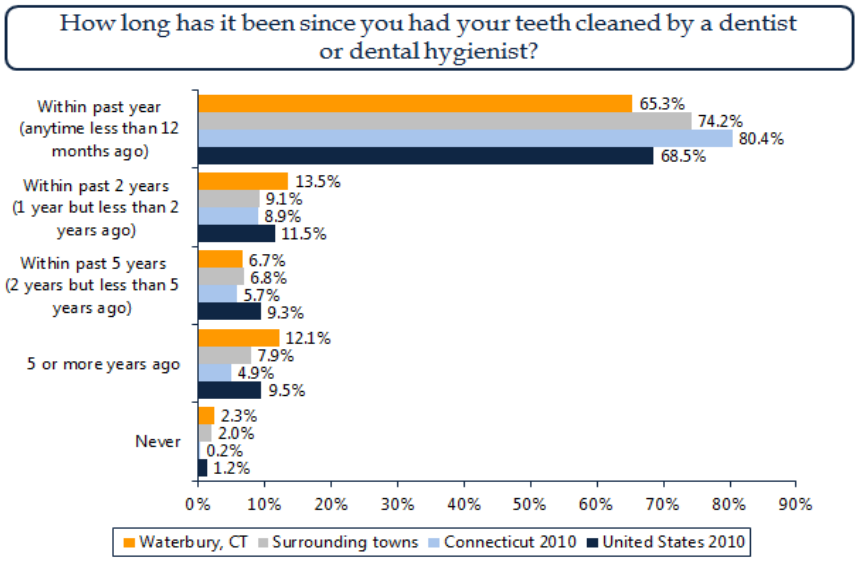
Immunizations

A positive finding among Waterbury respondents is the prevalence of immunizations. In the past 12 months, 51.8% of respondents received a flu vaccine either as a shot or a nasal spray compared to 45.2% in Connecticut and 41.3% in the nation. In addition, 35.5% received a pneumonia shot compared to 30.9% in Connecticut and 30.6% in the nation.

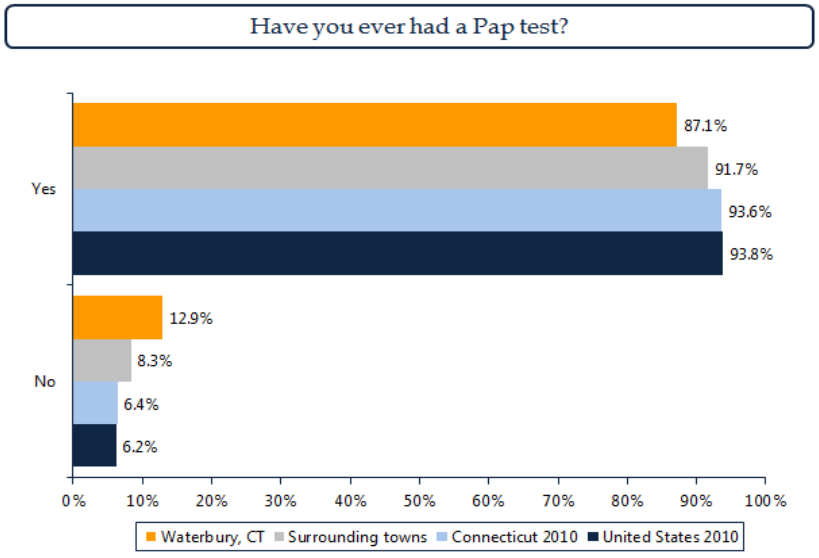


Screenings

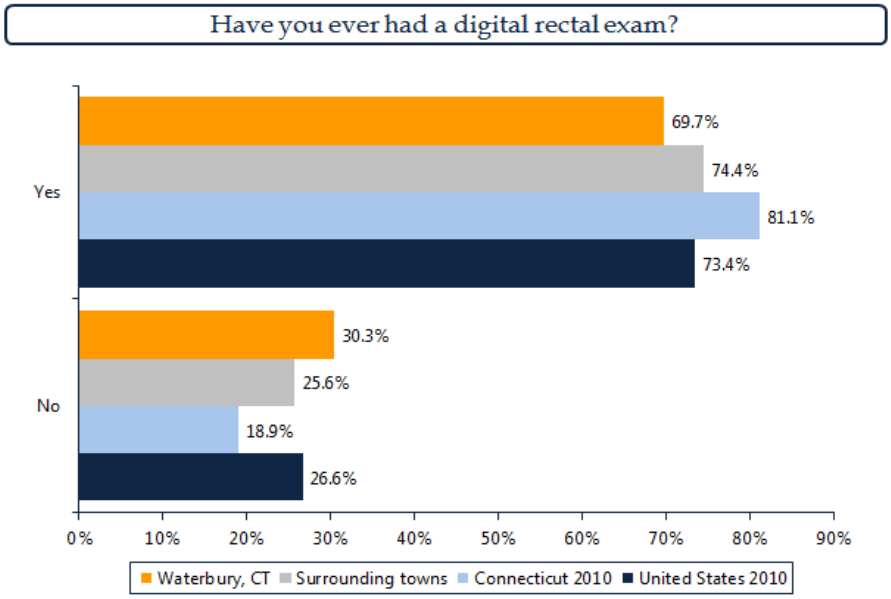
In general, Waterbury residents are less likely to engage in preventative oral health practices. Only 60.8% of respondents visited a dentist or a dental clinic within the past year. This is consistent with the nation (68.1%), but notably lower when compared to Connecticut (80.6%). Waterbury respondents are also less likely to have had their teeth cleaned (65.3%) within the past year when compared to both the state (80.4%) and the nation (68.5%).



Female preventative screenings are also less prevalent among Waterbury residents. Women are less likely to have ever received a mammogram, clinical breast exam, or Pap test when compared to women across Connecticut and the nation. The percentage of Waterbury women receiving a Pap test is of particular concern as only 87.1% have ever had one compared to 93.6% in Connecticut and 93.8% in the nation. The percentage of women receiving clinical breast exams (87.8%) is also concerning when compared to all of Connecticut (92.4%).



Men ages 39 and older have a greater risk for prostate cancer and should receive regular diagnostic screenings. Male respondents in Waterbury are more likely to have had one of the suggested screenings, a prostate-specific antigen test (57.5%), when compared to men across the nation (51.1%). However, they are less likely to have the second suggested screening, a digital rectal exam (69.7%), when compared to men across Connecticut (81.1%) and the nation (73.4%). In addition, of the men who have had a digital rectal exam, fewer had it within the past year. This is a potential health concern since male respondents in Waterbury are more likely to have prostate cancer (6.0%) when compared to the nation (3.5%).



Colorectal cancer can be screened for through home blood stool tests and sigmoidoscopies/ colonoscopies. Waterbury respondents are slightly more likely to have had a sigmoidoscopy/ colonoscopy when compared to the nation, but notably less likely to have had a home blood stool test (27.7%) when compared to the nation (45.4%). Of those respondents who have had a home blood stool test, a large proportion last had one five or more years ago (35.0%).

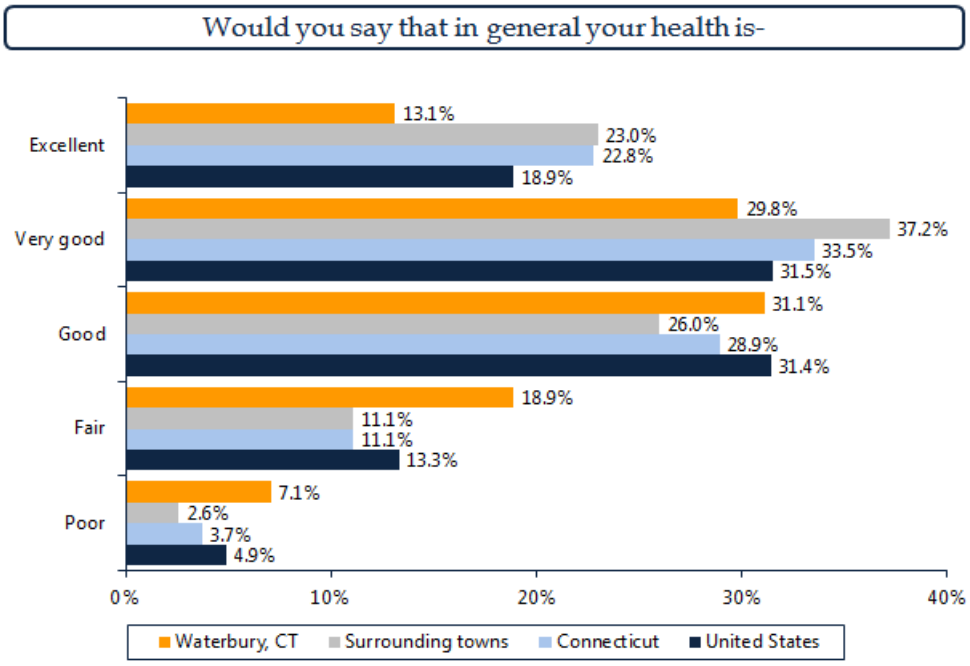
Residents in Waterbury are more likely to have been tested for HIV (55.7%) when compared to residents across Connecticut (36.7%) and the nation (37.4%). By itself, this is a positive finding. However, additional data suggests that a possible reason for higher screening rates is the prevalence of high risk behaviors. Approximately 7% of Waterbury respondents said that high risk situations like intravenous drug use and sexually transmitted diseases apply to them. This compares to 3.6% across Connecticut and 3.8% across the nation.

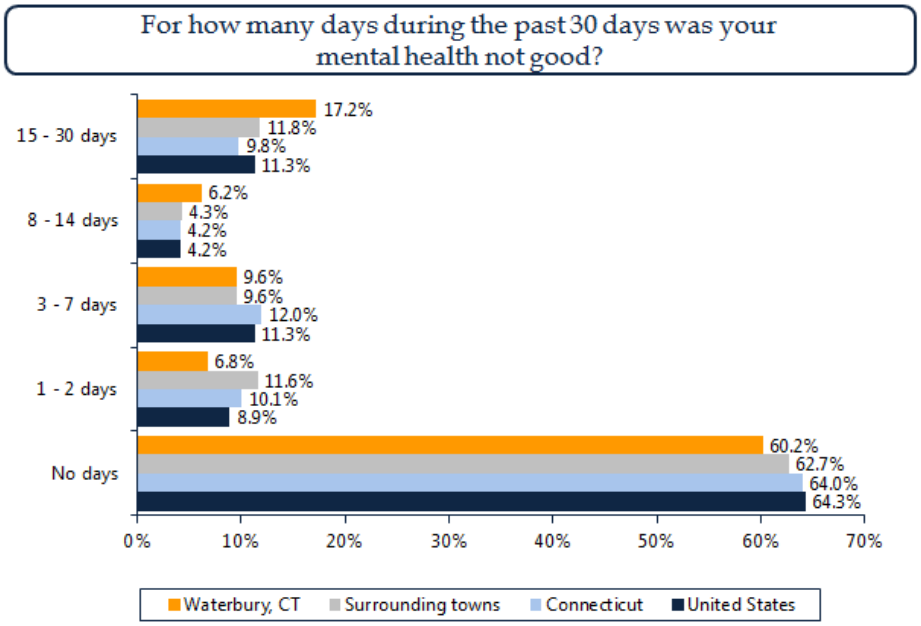
Health Status & Chronic Health Issues

Physical & Mental Health

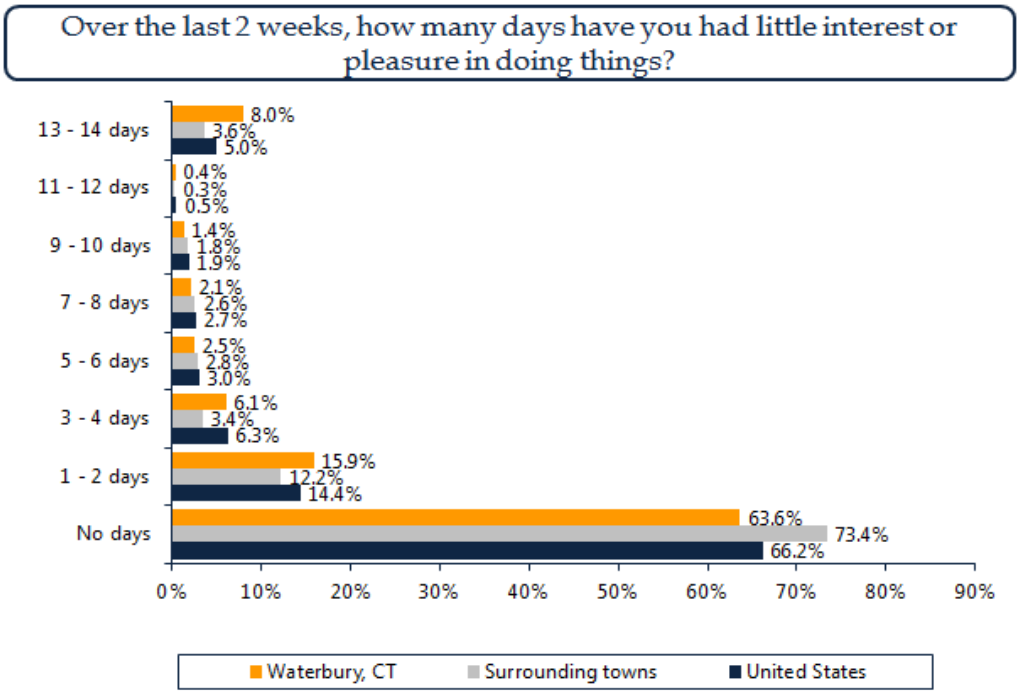
Residents of Waterbury are more likely to report having fair or poor health in general. Only 13.1% of respondents said that their health was excellent, compared to Connecticut (22.8%) and

the nation (18.9%). In addition, during the past 30 days, 40.8% of respondents said that they had at least one day of poor physical health and 39.8% said that they had at least one day of poor mental health. Of particular concern is the 17.2% of respondents who said that they had 15 – 30 days of poor mental health during the past 30 days. This compares to 9.8% across Connecticut and 11.3% across the nation. The combination of poor physical and mental health days kept 45.3% of respondents from doing their usual activities on at least one of the past 30 days.





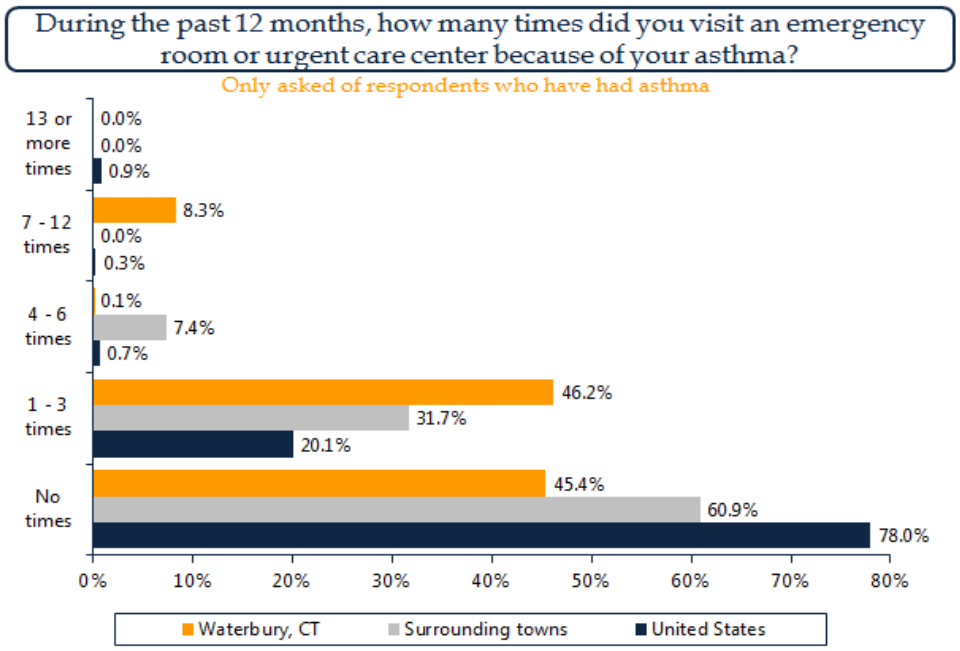
In addition to having more days of poor mental health, Waterbury respondents are more likely to have been diagnosed with an anxiety disorder and to have felt depressed and had little interest in doing things. The percentage of Waterbury respondents who have been diagnosed with an anxiety disorder is 19.7%. This compares to 16.7% across the nation. Over the last two weeks, 36.4% of respondents had little interest or pleasure in doing things and 34.3% felt down, depressed, or hopeless. A positive finding is that more respondents (16.4%) are taking medicine or receiving treatment from a health professional for their mental health condition when compared to the nation (12.5%).



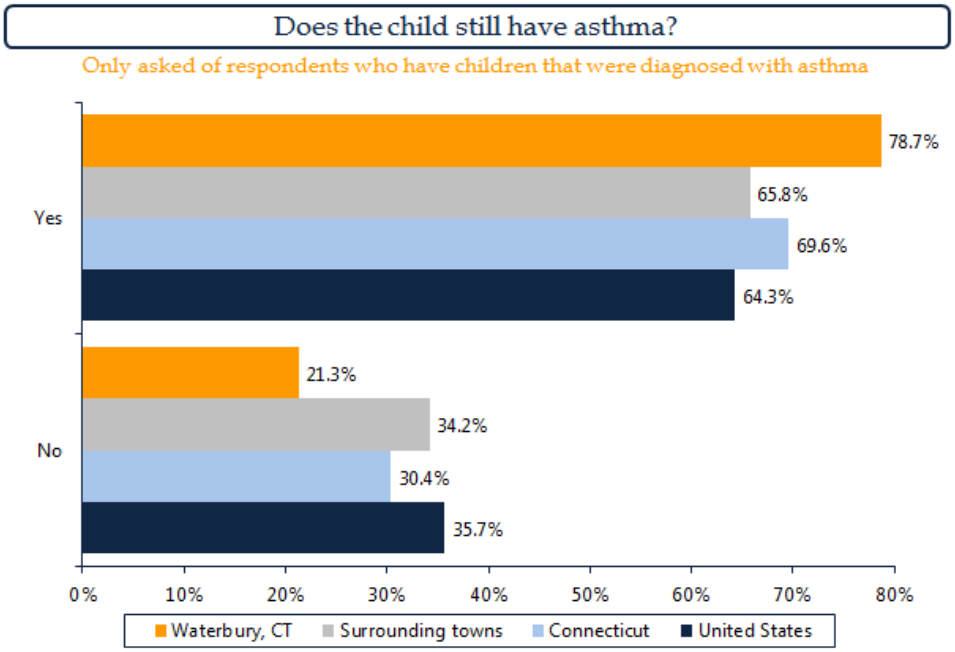
A contributing factor to the poor mental health status of Waterbury residents may be the proportion of residents who are acting as caregivers for friends or family members. During the past month, 27.1% of respondents provided caregiver services compared to 15.6% across Connecticut and 16.8% across the nation.

Chronic Health Issues

A number of chronic conditions are of concern in Waterbury, including asthma, cardiovascular disease, and diabetes. Approximately 22% of Waterbury respondents had been told that they have asthma. This compares to 14.8% in Connecticut and 13.5% in the nation. Additional data also suggests that asthmatics in Waterbury are not managing their condition as well. A higher proportion have had an asthma attack (59.2%) and visited an emergency room or urgent care center in the past year (54.6%) when compared to the nation (43.0%; 22.0%). A higher proportion has also been unable to carry out their usual activities because of their asthma (39.5%) when compared to the nation (23.8%).

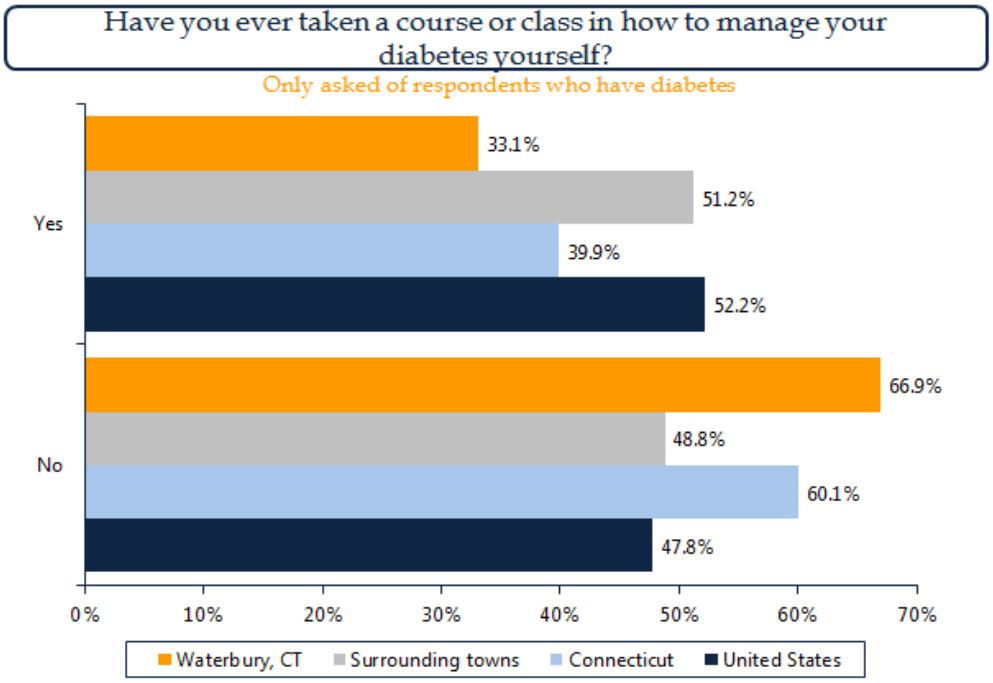


Children in Waterbury are also disproportionately affected by asthma. Slightly more than 21% have been diagnosed with asthma compared to 15.0% in Connecticut and 13.4% in the nation. They are also more likely to still have asthma (78.7%) when compared to Connecticut (69.6%) and the nation (64.3%).



Residents in Waterbury are more likely to have cardiovascular health issues like heart attacks (6.6%), angina or coronary heart disease (5.9%), and stroke (5.4%). A contributing factor (other than obesity and lack of physical activity) may be high blood pressure. A higher proportion of Waterbury residents have high blood pressure (33.6%) when compared to Connecticut (29.7%) and the nation (31.6%) and fewer are taking medicine for it.

A higher proportion of residents in Waterbury have been diagnosed with diabetes (14.8%) when compared to Connecticut (9.3%) and the nation (9.8%). This is a concern for the community in terms of prevention, but even more concerning is that diabetics in Waterbury are less likely to manage their condition. Fewer diabetics are taking insulin, checking their blood glucose levels on a daily basis, seeing a health professional for their condition, having a health professional conduct an A1C test or foot check, and attending self-management courses. Specifically, only 33.1% of diabetic respondents have taken a course in how to manage their diabetes compared to 39.9% of diabetics across Connecticut and 52.2% of diabetics across the nation.



Household Telephone Survey Summary of Findings

A number of areas of opportunity were identified through the household telephone survey. The first area was access to care. Residents are more likely to have trouble affording out-of-pocket expenses despite having equitable health insurance coverage. They are also less likely to receive preventive screenings related to oral health and women's health. The second area was chronic health conditions. Respiratory conditions presented as an issue with a higher proportion of residents saying that they and their children have asthma. A contributing factor to asthma rates may be the proportion of residents who smoke cigarettes. Cardiovascular disease and diabetes

also presented as concerns among residents. Contributing factors to these conditions may be the proportion of residents who are overweight or obese and have high blood pressure. The third area was the mental health status of Waterbury. Residents have more days of poor mental health, are more likely to experience depression and be diagnosed with an anxiety disorder.

FOCUS GROUPS OVERVIEW

Background

A total of six focus groups were held at various locations throughout Waterbury in February 2013. Two of the groups were conducted with health care providers associated with the two hospitals; four groups were conducted with members of neighborhood associations. Focus group topics addressed access to care, cultural competency, physical activity, nutrition/healthy eating habits, weight/obesity, and health information. Each session lasted approximately 90 minutes and was facilitated by trained staff from Holleran.

Participants were recruited through the CHNA partners. In exchange for their participation, health care providers were given a $25 gift card; community members received $25 cash. Two discussion guides developed in consultation with the Greater Waterbury Health Improvement Partnership, were used to prompt discussion and guide the facilitation.

In total, 57 people participated in the focus groups. It is important to note that the results reflect the perceptions of a limited number of providers and community members and may not necessarily represent all providers and residents of Waterbury.

The following section provides a summary of the focus group discussions including key themes and select comments.

Health Care Provider Focus Groups Key Findings

Access to Care

Access to care was an area of shared concern among Saint Mary's and Waterbury Hospital physicians. Physicians agreed that the greatest barriers to accessing care in Waterbury are an inadequate number of physicians, particularly primary care physicians, and health insurance-related issues. The primary care shortage in Waterbury has prohibited patients from having assured and timely access to care, even if they are insured. Many patients with medical homes are still using the ED due to the limited hours of clinics and the overwhelming demand for limited appointment slots. Participants also pointed out that primary care physicians are the lowest paid providers and care for the most challenging payer mix.

Participants shared that low Medicaid reimbursements limit the number of patients that primary and specialty physicians are willing to see. One physician stated, "It costs us more to see the

patients than what we receive in reimbursement." Additional barriers to accessing care included a lack of awareness of available services among eligible patients, limited bilingual services for non-English speaking residents, transportation, and co-payments. Another physician stated, "Even residents with health insurance are financially stressed and don't follow through on their care due to copayment costs."

There was general consensus among providers that patients with mental and/or behavioral health issues are underserved. It is difficult for these patients to receive the care that they need because providers are hesitant to "take responsibility for them" and services are limited. Providers are reluctant to be the "physician of record." Other underserved populations included the seasonally insured, service industry workers, and minority populations.

Participants listed a number of resources for uninsured and underinsured residents. The Waterbury Health Access Program (WHAP) was seen as particularly successful in linking needy patients with volunteer physicians and insurance. Lack of funding could jeopardize the future of the program.

Key Health Issues and Challenges

Mental and behavioral health issues were seen as key health issues in the community. One physician suggested that there was "widespread emotional despair" within the city. Other concerns were that elderly patients suffered from dementia, late-stage breast cancer diagnoses, and obesity.

Related to obesity, participants saw a number of challenges for residents trying to stay physically fit and eat a healthy diet. Fresh fruits are expensive and not widely available following recent closings of several supermarkets. An increase in farmers' markets was seen as a positive development. Other barriers included residents' awareness of healthy diets, as well as their willingness to dedicate resources to costly fruits and vegetables (over less expensive fast food alternatives). Compounding challenges to maintaining health, a lack of accessible, safe recreational areas was noted.

Participants provided several recommendations for improving the health of the community. Better patient navigation, extended clinic hours to serve residents instead of the ED, and higher reimbursement for Medicaid patients, were among recommendations provided. Participants agreed that mental health treatment options also needed to be expanded. Investments to improve poor economic conditions in the city needed to continue.

Provider Resources

Providers agreed that insurance-related issues are one of the top obstacles that they face in providing care. The amount of paperwork required by each plan burdens medical offices and takes away from direct patient care. Providers also stated that a merger between the two hospitals in Waterbury would create more seamless care and financial stability that would allow for more modern technology.

Local health departments were viewed as helping to meet the needs of the Waterbury community; however, most participants were not aware of specific activities. The general consensus was that more support from entities across the community was needed. One participant stated, "It comes down to shared responsibility. Everyone needs to take a part."

Community Resident Focus Groups Key Findings

Access to Care

A number of issues were identified by community residents as barring people from accessing health care. Many issues were centered on the cost of care. Participants identified lack of health insurance, the cost of copayments and medications, and increasing premiums and deductibles, specifically. They also expressed concern that Husky Care (Medicaid) was often not accepted by providers and that people were "looked down upon" for having it. Other issues included transportation, clinic hours of operation, language barriers, lack of awareness of services, and legal status. Participants stated that it can "take all day" to see the doctor due to the limited number of bus stops and long wait times between rides. They also stated that the only place to receive care after hours was the ED since clinics and private medical offices were closed. Hispanics/Latinos and Albanian residents were viewed as most impacted by language barriers.

Participants felt that a number of populations within the community were not being adequately served by local health services. These included African Americans, Hispanics/Latinos, single mothers with children, the homeless, mentally ill residents, seniors, and teens. Participants explained that for those seniors who need assistance with Activities of Daily Living (ADL), traveling to the Veteran's Administration Hospital in West Haven (45 minutes away) is a burden. They also expressed that teens are often not able to afford medication and are struggling with issues like sexually transmitted diseases. Resources identified that cared for underserved populations included hospital EDs, health clinics, Planned Parenthood, and the Malta House of Care van.

Dental care and mental health care were viewed as lacking services in the community. Participants agreed that dental care is largely unavailable without insurance. There was general consensus that there was "no place to go" for mental health care services. One person stated, "You have to commit a crime to get mental health care."

Key Health Issues and Challenges

More than 10 health issues were identified as major concerns in the community. Among the issues, mental and behavioral health issues were mentioned several times. In particular, participants noted wide-spread abuse of medicines like Nyquil and addictions to pain medication. Several factors were seen as contributing to addictive behavior including long delays in getting appointments and automatic refilling of pain medication prescriptions. Participants also noted tobacco use as a major concern. They observed that "Everyone smokes

cigarettes." An increased popularity of small cigars due to the lower cost compared to cigarettes was noted.

Participants noted a number of challenges for people in the community trying to stay physically fit and eat healthier. There was broad agreement that Waterbury does not offer adequate opportunity for physical activity. Comments included: "There are no safe parks." "Sidewalks are not in good condition." "Streets are of an old design; they are not wheelchair or stroller friendly." "There are no bike trails." "Today's parks have crooked slides and broken sprinklers." "There are syringes on the ground."

Programs that are available for recreation have a cost associated with them. Two organizations, the Police Athletic League (PAL) and the YMCA, were seen as positive entities, although both have fees for participation. Participants agreed that fresh fruits and vegetables were available year-round, but that barriers like cost, transportation, and location keep residents from accessing them widely. The farmer's market was seen as a step in the right direction; however, one participant said "You have to fight your way through panhandlers and the homeless to shop there." One solution was to increase the number of community gardens in Waterbury.

A number of weaknesses related to the socio-economic and physical environment of the community were identified. Participants stated that there was a lack of jobs in the area and that youth didn't have work opportunities. Poverty conditions often caused parents to "hop from apartment to apartment" to avoid paying rent, causing school transfers and disruption to children's education. Blight, littering, and poor school conditions were also concerns. One participant stated, "Residents are not invested in the areas where they live."

Community Aspirations & Capacity

Participants offered a number of suggestions for improving the health of the community. Specific examples included expanding access to care by "bringing back" the StayWell Health Center van; sponsoring free dental clinics; offering more health screenings and smoking cessation programs; and promoting on-going health education campaigns. Cleaning up the city park, improving the transportation system, sponsoring more community gardens, and providing safe and clean public restrooms in the downtown area were suggested to improve the city environment.

Participants urged community organizations to concentrate on the city as a whole and work to improve the socio-economic factors burdening residents. They also cited the need for more general counseling services and community mentors for the youth. Participants thought that efforts needed to be made to "instill more pride in the city" in an effort to encourage more community involvement and advocacy. Religious organizations were seen as untapped resource in these efforts.

Focus Group Summary of Findings

The focus group participants were grateful for the opportunity to share their thoughts and experiences; many expressed support for community-wide efforts to improve the health status of Waterbury. Identified community strengths included area healthcare providers, specifically the hospitals, health clinics, and local health departments. Areas of opportunity included expanding access to care for residents, availability of resources to improve physical activity and healthy eating, and concerns of blight and community investment.

KEY INFORMANT INTERVIEWS OVERVIEW

Background

An online survey was conducted among area "Key Informants." Key informants were defined as community stakeholders with expert knowledge including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders.

Holleran staff worked closely with the Greater Waterbury Health Improvement Partnership to identify key informant participants and to develop the Key Informant Survey Tool. Two-hundred and five (205) completed surveys were collected between February and April 2013. A listing of key informant participants can be found in Appendix D.

The questionnaire focused on gathering qualitative feedback regarding perceptions of community needs and strengths across three key domains:

- Key Health Issues
- Health Care Access
- Challenges & Solutions

It is important to note that the results reflect the perceptions of some community leaders, but may not necessarily represent all community representatives within Waterbury.

Key Informant Study Findings

Key Health Issues

The first section of the survey focused on the key health issues facing the community. Individuals were asked to select the top health issues that they perceived as being the most significant. The issues that were most frequently selected were:

1. Mental/Behavioral Health
2. Overweight/Obesity
3. Access to Health Care/Uninsured/Underinsured
4. Substance Abuse/ Alcohol Abuse
5. Heart Disease

The following table shows the breakdown of the percent of respondents who selected each health issue. Issues are ranked from top to bottom based on number of participants who selected the health issue as one of their top five issues. The first column depicts the total percentage of respondents that selected the health issue as one of their top five. Respondents were also asked of those health issues mentioned, which one issue is the most significant. The second column depicts the percentage of respondents that rated the issue as being the most significant of their top five.

Table 1: Ranking of Key Health Issues

Rank	Health issue	Percent of respondents who selected the issue	Percent of respondents who selected the issue as the most significant
1	Mental/Behavioral Health	78%	32%
2	Overweight/Obesity	66%	14%
3	Access to Health Care/ Uninsured/Underinsured	63%	26%
4	Substance Abuse/Alcohol Abuse	61%	7%
5	Heart Disease	42%	5%
6	Diabetes	41%	2%
7	Cancer	34%	7%
8	Caregiver Needs	30%	4%
9	Dental Health	21%	0%
10	Tobacco	20%	1%
11	Maternal/Infant Health	16%	1%
12	Stroke	11%	1%
13	Sexually Transmitted Diseases	7%	0%
14	HIV/AIDS	6%	1%

Figure 1 shows the key informant rankings of all the key health issues. The bar depicts the total percentage of respondents that ranked the issue in their top five.

"What are the top 5 health issues you see in your community?"

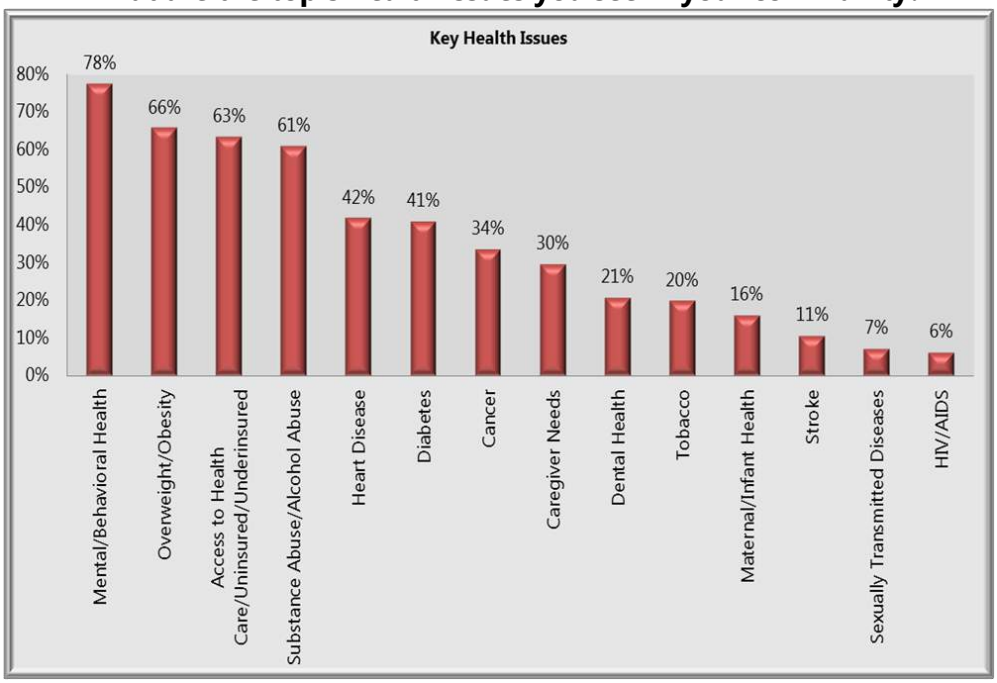


Figure 1: Ranking of key health issues

Health Care Access

Availability of Services

The second set of questions concerned the ability of local residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bilingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). The results are displayed in Table 2.

Health care access appears to be a significant issue in the community. As illustrated in Table 2, none of the informants strongly agree to any of the health care access factors. Most respondents 'Disagree', with community residents' ability to access care. Availability of mental/ behavioral health providers garnered the lowest mean responses (2.06), compared to the other factors.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access."

Table 2: Mean Responses for Health Care Access Factors

Factor	Mean Response	Corresponding Scale Response
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	3.19	Neither agree nor disagree
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	2.90	Disagree
Residents in the area are able to access a dentist when needed.	2.93	Disagree
There are a sufficient number of providers accepting Medicaid and medical assistance in the area.	2.33	Disagree
There are a sufficient number of bilingual providers in the area.	2.40	Disagree
There are a sufficient number of mental/ behavioral health providers in the area.	2.06	Disagree
Transportation for medical appointments is available to residents in the area when needed.	2.53	Disagree

Barriers to Health Care Access

After rating availability of health care services, the informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Inability to Pay Out-of-Pocket Expenses (co-pays, prescriptions, etc.)
- Lack of Health Insurance Coverage
- Inability to Navigate Health Care System

Table 3 shows the breakdown of the number and percent of respondents who selected each barrier. Barriers are ranked from top to bottom based on the frequency of participants who selected the barrier. The third column in the table depicts the percentage of respondents that rated the barrier as being the most significant facing the community.

"What are the most significant barriers that keep people in the community from accessing health care when they need it?"

Table 3: Ranking of Barriers to Health Care Access

Rank	Barrier to Health Care Access	Number of respondents who selected the issue	Percent of respondents who selected the issue	Percent of respondents who marked it as the most significant barrier
1	Inability to Pay Out of Pocket Expenses	151	80%	19%
2	Lack of Health Insurance Coverage	135	71%	20%
3	Inability to Navigate Health Care System	131	69%	26%
4	Lack of Transportation	107	57%	4%
5	Language/Cultural Barriers	86	46%	1%
6	Basic Needs Not Met (Food/Shelter)	80	42%	8%
7	Time Limitations	82	43%	3%
8	Availability of Providers/Appointments	80	42%	14%
9	Lack of Child Care	45	24%	1%
10	Lack of Trust	42	22%	2%

Figure 2 shows a graphical depiction of the frequency of selected barriers to health care access.

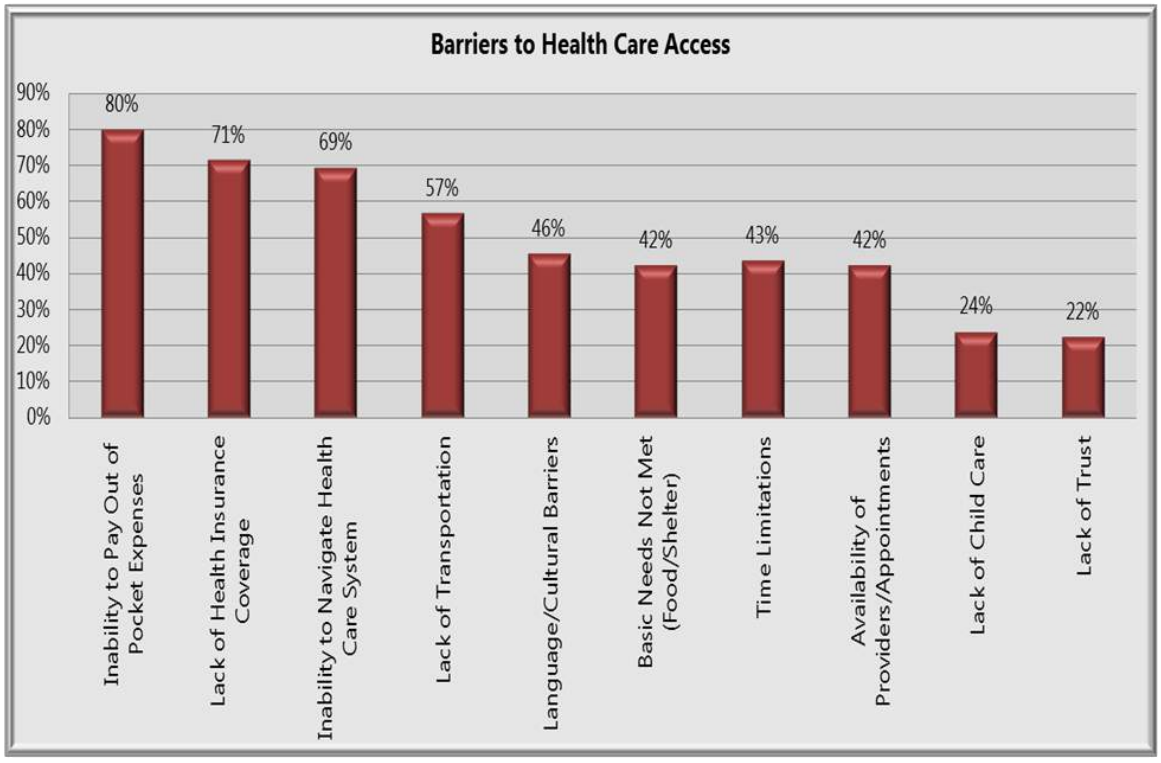


Figure 2: Ranking of barriers to health care access

Underserved Populations

Informants were then asked whether they thought there were specific populations who are not being adequately served by local health services. As seen in Figure 3, the majority of respondents (82%) indicated that there are underserved populations in the community.

"Are there specific populations in this community that you think are not being adequately served by local health services?"

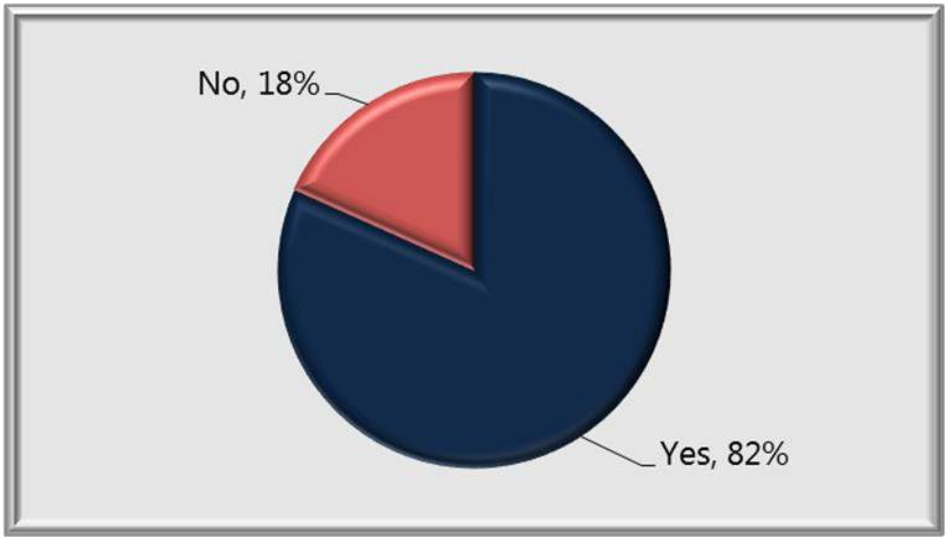


Figure 3: Key informant opinions regarding underserved populations

Those respondents were asked to identify which populations they thought were underserved. The results can be found in Table 4 below. Uninsured/underinsured and low-income/poor individuals were considered underserved populations along with homeless individuals and seniors/aging/elderly individuals. In addition, several respondents felt that racial/ethnic minorities and immigrant/refugee population were underserved.

Table 4: Underserved Populations

	Underserved population	Number of respondents selecting the population
1	Uninsured/Underinsured	98
2	Low-income/Poor	82
3	Homeless	64
4	Seniors/Aging/Elderly	41
5	Hispanic/Latino	35
6	Immigrant/Refugee	33
7	Black/African-American	31
8	Children/Youth	29
9	Disabled	28
10	Young Adults	22
11	Lower Middle Class	3
12	Mental Health/Addicts	1
13	Veterans	1
14	LGBT	1

Health Care for Uninsured/Underinsured

Next, the informants were asked to select where they think most uninsured and underinsured individuals go when they are in need of medical care. As shown in Figure 4, the majority of respondents (81%) indicated that uninsured and underinsured individuals go to the Hospital Emergency Department for medical care.

In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care?

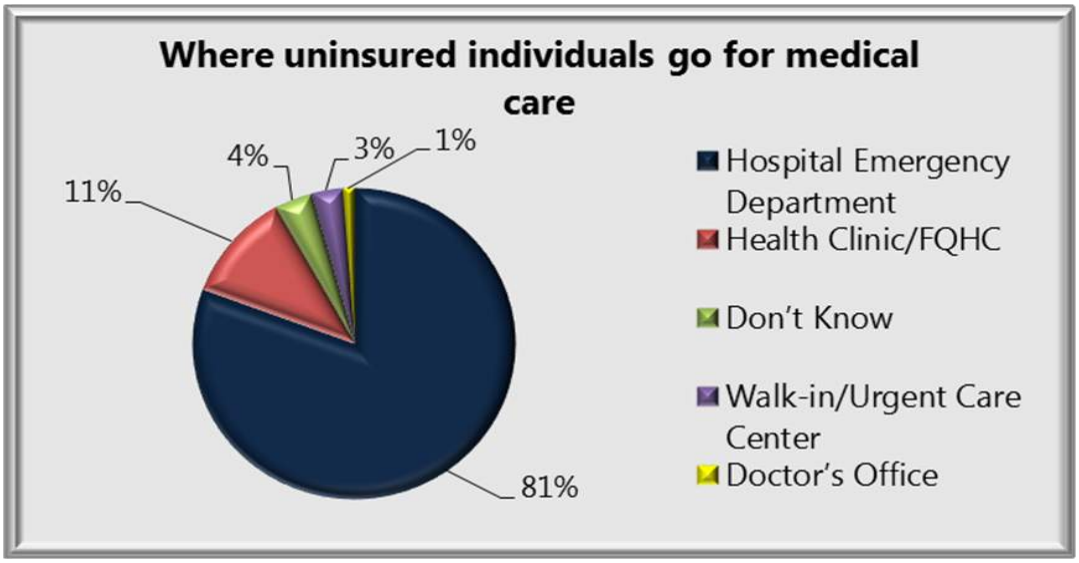


Figure 4: Key informant opinions of where uninsured individuals receive medical care

Resources Needed to Improve Access

Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many respondents indicated that free and low cost medical and dental care, and mental health services are needed. In addition, informants want to see more health education and outreach and more transportation/assisted transportation. Table 5 includes a listing of the resources mentioned ranked in order of the number of mentions.

Table 5: Listing of Resources Needed in the Community

Rank	Resources Needed	Number of Mentions
1	Free/Low Cost Dental Care	111
2	Mental Health Services	108
3	Free/Low Cost Medical Care	93
4	Health Education/Information/Outreach	78
5	Transportation/Assisted Transportation	69
6	Health Screenings	63
7	Bilingual Services	58
8	Prescription Assistance	58
9	Substance Abuse Services	52
10	Primary Care Providers	39
11	Medical Specialists	32
12	Free/Low Cost Dental Care	111

Challenges & Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community.

When asked what challenges people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort
- Education/Knowledge
- Chronic Conditions/Diseases
- Cultural Norms
- Environment/Safety

Next, key informants were asked "What recommendations or suggestions do you have to improve health and quality of life in the community?" Several major themes emerged from the comments including the following:

- Increased Awareness/Education/Community Outreach
- Increased Collaboration/Coordination
- Improved Access to Medical Care, Dental Care, and Mental Health Services
- Improved Access to Affordable Exercise and Nutrition Programs
- Need For Patient Navigation
- Enhanced Programs/Outreach for Youth and Seniors
- Enhanced Community Space

Key Informant Interviews Summary of Findings

Key informants acknowledged that mental/behavioral health, overweight/obesity, and access to care are the most significant health issues in the community. Related to access to care, informants agreed that residents do not have sufficient access to providers and experience a number of barriers in seeking care. In particular, they felt that residents are not able to see specialists, dentists, and mental/behavioral health providers when they need to. They also felt that there are not enough bilingual providers and providers accepting Medicaid and medical assistance. Additional barriers for residents seeking care are out-of-pocket expenses, lack of health insurance coverage, and the inability to navigate the health care system. Informants recommended a number of resources to improve access to care. Among these, free/low cost dental care, mental health services, and free/low cost medical care were cited the most.

Eighty-two percent of informants agreed that there are underserved populations living in Waterbury. Of these populations, they felt that the uninsured/underinsured, low-income/poor, and homeless are the most underserved. When seeking medical care, these populations were thought to most often utilize hospital emergency departments and federally qualified health centers/clinics.

The last portion of the survey asked key informants to identify challenges in the community in maintaining healthy lifestyles and to make recommendations or suggestions for improving health and quality of life. In addition to issues related to access to care, informants listed motivation/effort, education/knowledge, cultural norms, and environment/safety as challenges in the community. To address these issues, informants recommended increasing awareness, education, community outreach, and community collaboration and coordination. They also suggested that more programs for youth and seniors be offered and that the community space be enhanced.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS & PLANNING

Prioritization Session

On June 17, 2013, approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for the development of the hospital's Implementation Strategy. A list of attendees can be found in Appendix G.

Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans. Master list of community priorities (Presented in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

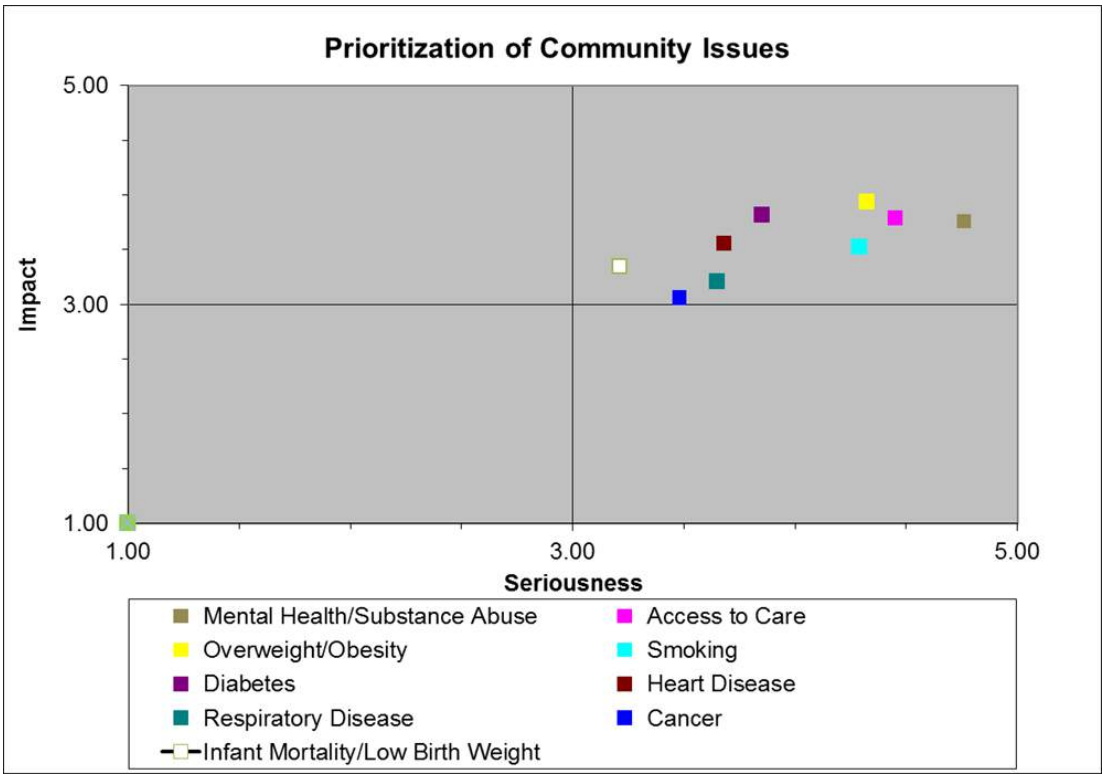
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Goal Setting

Following the prioritization session, The Greater Waterbury Health Improvement Partnership representatives met to review the identified priorities and develop goal statements to guide community-wide health improvement efforts. The following goals were adopted for each priority area:

Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Overweight and Obesity

Goal: Promote health and reduce chronic disease through healthful eating and physical activity.

Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Action Planning

To set a course for ongoing community health improvement activities and evaluation, a Community Health Improvement Plan (CHIP) was developed by the Greater Waterbury Health Partnership. Additionally, in line with requirements set forth in the ACA, specific Implementation Strategies, outlining how each hospital would work to address the identified needs, were created.

The CHIP and Hospital Implementation Strategies were adopted in September 2013. These documents, as well as a report of the CHNA are available on the partner websites.

APPENDIX A: Secondary Data Profile References

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APPENDIX B: Household Telephone Study Statistical Considerations

The Household Telephone Study sampling strategy was designed to represent Waterbury and its surrounding towns. The sampling strategy identified the number of completed surveys needed within each ZIP code based on the population statistics from the U.S. Census Bureau in order to accurately represent the area. Call lists of household land-line telephone numbers were created based on the sampling strategy. The final sample (1,121) yields an overall error rate of +/-2.9% at a 95% confidence level. This means that if one were to survey all residents of Waterbury, the final results of that analysis would be within +/-2.9% of what is displayed in the current data set.

Data collected from the 1,121 respondents was aggregated and analyzed by Holleran using IBM SPSS Statistics. The detailed survey report includes the frequency of responses for each survey question. In addition, BRFSS results for Connecticut and the United States are included when available to indicate how the health status of Waterbury residents compares on a state and national level. All comparisons represent 2011 BRFSS data unless otherwise noted. It is important to note a few questions on the survey did not have comparisons to Connecticut and/or national data because of survey modifications.

It is common practice in survey research to statistically weight data sets to adjust for demographic imbalances. For example, in the current household survey, the number of females interviewed is above the actual proportion of females in the area. The data was statistically weighted to correct for this over-representation of females. It should be noted that the national dataset (from the CDC) is also statistically weighted to account for similar imbalances.

APPENDIX C: Household Telephone Study Participant Demographics

Gender and Age

Demographic Category		Waterbury CT 2013 BRFSS (n = 743)	Surrounding Towns 2013 BRFSS (n = 378)
Gender	Male	36.7%	35.4%
	Female	63.3%	64.6%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 735)**	**Surrounding Towns 2013 BRFSS (n = 374)**
Age Group	18 - 24	2.9%	4.8%
	25 - 34	9.0%	5.3%
	35 - 44	10.2%	12.8%
	45 - 54	17.0%	22.7%
	55 - 64	24.4%	21.7%
	65 years and over	36.6%	32.6%

Race and Ethnicity

Demographic Category		Waterbury CT 2013 BRFSS (n = 737)	Surrounding Towns 2013 BRFSS (n = 378)
Hispanic/Latino	Yes	13.0%	2.6%
	No	87.0%	97.4%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 715)**	**Surrounding Towns 2013 BRFSS (n = 377)**
Race	White	73.6%	94.4%
	Black or African American	16.5%	0.8%
	Asian	1.8%	1.6%
	Native Hawaiian or Other Pacific Islander	0.4%	0.0%
	American Indian or Alaska Native	1.4%	0.5%
	Other	6.3%	2.7%

Marital Status and Children

Demographic Category		Waterbury CT 2013 BRFSS (n = 734)	Surrounding Towns 2013 BRFSS (n = 376)
Marital Status	Married	36.2%	58.0%
	Divorced	16.9%	13.0%
	Widowed	17.8%	13.8%
	Separated	3.0%	0.8%
	Never Married	22.9%	12.5%
	Member of an unmarried household	3.1%	1.9%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 742)**	**Surrounding Towns 2013 BRFSS (n = 378)**
Number of Children in Household	None	74.5%	70.9%
	One	12.3%	14.3%
	Two	8.1%	12.2%
	Three	3.2%	2.4%
	Four	1.1%	0.0%
	Five	0.7%	0.3%
	Six	0.1%	0.0%

Educational Attainment

Demographic Category		Waterbury CT 2013 BRFSS (n = 739)	Surrounding Towns 2013 BRFSS (n = 376)
Education Level	Never attended school or only attended kindergarten	0.4%	0.5%
	Grades 1 through 8	3.7%	2.1%
	Grades 9 through 11	6.5%	2.1%
	Grade 12 or GED	31.9%	20.7%
	College 1 year to 3 years	31.8%	27.1%
	College 4 years or more	25.7%	47.3%

Employment Status

Demographic Category		Waterbury CT 2013 BRFSS (n = 741)	Surrounding Towns 2013 BRFSS (n = 376)
Employment Status	Employed for wages,	38.9%	49.2%
	Self-employed,	3.6%	10.1%
	Out of work for more than 1 year,	4.3%	2.7%
	Out of work for less than 1 year,	2.8%	1.6%
	Homemaker,	3.5%	3.2%
	Student,	1.3%	1.9%
	Retired, or	34.5%	26.9%
	Unable to work	10.9%	4.5%

Income

Demographic Category		Waterbury CT 2013 BRFSS (n = 574)	Surrounding Towns 2013 BRFSS (n = 301)
Income	Under $10,000	8.4%	2.0%
	$10,000 to less than $15,000	13.2%	5.3%
	$15,000 to less than $20,000	6.6%	2.3%
	$20,000 to less than $25,000	10.8%	4.3%
	$25,000 to less than 35,000	14.5%	8.3%
	$35,000 to less than 50,000	14.1%	12.6%
	$50,000 to less than 75,000	14.6%	17.9%
	$75,000 or more	17.8%	47.2%

APPENDIX D: Key Informant Participants

Name	Title	Organization
Tina Agati	Executive Director	Literacy Volunteers of Greater Waterbury
Eric Albert	President	Albert Brothers, Inc.
Michele A. Albini	Constituent Service Aide	City of Waterbury
Janine Altamirano	Program Coordinator	Waterbury Department of Public Health
Maryangela Amendola	Director	Chase Family Resource Center
Joel Becker	President & Chief Executive Officer	Torrco
Carolann Belforti	JobLinks Coordinator	Northwest Regional Workforce Investment Board
Michelle Bettigole	Executive Director	The Watermark at East Hill
Christine Bianchi, MSW, LCSW	Chief Developmental Officer	Staywell Health Care, Inc.
O. Joseph Bizzozero, MD	Administration	Alliance Medical Group
Charles Boulier	President & Chief Executive Officer	Naugatuck Savings Bank
Samuel Bowens	HIV Prevention Coordinator	Waterbury Health Department
Betty Bozzuto	Chief Nursing Officer	Saint Mary's Hospital
Ellen Brotherton	Assistant Director	Western CT Mental Health Network - Waterbury
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Katherine Carten	Parish Administrator	Saint Michael's Parish, Naugatuck
Ellen Carter	Program Officer	Connecticut Community Foundation
Kathy Case	Director of Program Management	Waterbury ARC
Julie Clark	Wellness Environmental Lifestyle Consultant	
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Meghan Cleary	Director of Nursing	Wolcott View Manor
Mary Conklin	Housing Attorney	Connecticut Legal Services
Joseph G. Conrad	Program Director	Connecticut Counseling Centers, Inc.
Ronald Conti	Vice President	Heritage Village
Marilyn Cormack	President	BHCare
JoAnne Cosgriff, MD	Director, Performance Improvement	Waterbury Hospital
Janice Crelan	Assistant Treasurer	Hubbard-Hall, Inc.
Kelly Cronin	Executive Director	Waterbury Youth Services
Andrea Cuff, APRN		Chase Outpatient
Jerome Dais	Elder	Family Worship Center
Kristen Davila	Director	Morris Senior Center
Nancy Deming	Director	VNA Northwest
Catherine R. Dinsmore	Senior Center Director	Falls Avenue Senior Center
Deborah Duarte	Missions President	Community Tabernacle Outreach Center
Richard Dumont	Community Resident	
Kris Durante	Coordinator	Bridge To Success
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Tim Epperson	Food Pantry Coordinator	Greater Waterbury Interfaith Ministries
Michelle Fica	Managing Attorney	Connecticut Legal Services
Bethany Ann Fickes	Office Assistant	Saint Mary's Hospital
Christina Fishbein	Executive Director	Western Connecticut Area Agency on Aging
Ron Flormann	Chief Commercial Officer	Glenwood Systems, LLC
Natalie Forbes	Grant Coordinator	Waterbury Hospital
Auguste Fortin, VI, MD	Physician	Yale Primary Care Residency Program/ Waterbury Hospital
Yvette Highsmith Francis	Regional Director	Community Health Center, Inc.
Todd Gaertner	Nursing Home Administrator	Lutheran Home of Southbury

Sarah Geary	Constituent Services Manager	City of Waterbury
Sharon Gesek	Director of Elderly Services	Town of Southbury
Bill Gibbs	Owner	Bill Gibbs Massage Therapy
Mary-Kate Gill	Director of Elder Services	New Opportunities, Inc.
Jackie Giordano, RN	Nurse	Saint Mary's Hospital
Michelle Godin	Director	Saint Mary's Hospital
Joe Gorman	Supervisor of Health & Physical Education	Waterbury Board of Education
Lydia Granitto	Membership & Marketing Manager	Girl Scouts of Connecticut
Bernadette Graziosa	President	The Grotto Restaurant & Mrs. G's Gift Baskets
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Joy Hall	Director	Salvation Army
Lori Hart	Director	Bridge To Success
Robyn Hawley	Director of Behavioral Health	Catholic Charities Archdiocese of Hartford
Eileen Healy	Executive Director	Independence Northwest, Inc.
Tina Herman	Assistant Director of Critical Care	Waterbury Hospital
Arlene G. Herrick	Property Manager	Grace Meadows Elderly Housing
Chris Hibbs	Health & Wellness Director	Greater Waterbury YMCA
Stephen Holt	Assistant Professor	Yale Primary Care Residency
Geralyn Hoyt	Chief	Southbury Ambulance
Lucia Hughes	Manager	Waterbury Hospital
Stephen Huot, MD	Director	Yale Primary Care Residency Program/ Waterbury Hospital
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Eric Hyson, MD	Attending Physician	Waterbury Hospital
Sandi Iadarola	Chief Nursing Officer	Waterbury Hospital
Azhar Imam, MD	Chief of Psychiatry	Saint Mary's Hospital
Kristen Jacoby, MPH	President/Chief Professional Officer	United Way of Greater Waterbury
Donna Johnson	Community Relations Liaison	Diagnostic Radiology Associates
Mark Johnson, LMFT	Program Director	Wellspring Foundation
Jan Kennedy	Executive Director	Cardiology Associates of Greater Waterbury, LLC
Elizabeth Korn, APRN	Nurse	Saint Mary's Hospital
Lisa Labonte	SNS Director	New Opportunities, Inc.
Leo Lavallee	Principal	Waterbury Arts Magnet School
Stephen Lewis	Chief Executive Officer/President	Thomaston Savings Bank
The Rev. Jeanne Lloyd	Minister	Mattatuck Unitarian Universalist Society
Ben Loveland	Assistant Director	Waterbury Hospital
Vanessa Lucewicz	Practice Manager	Franklin Medical Group
Frederick Luedke	Chairman, Board of Greater Waterbury Health Network Inc.	Waterbury Hospital
Neal Lustig	Director of Health	Pomperaug Health District
Robin Marino	Clinical Manager	Saint Mary's Hospital
Judith Martin	Program Coordinator	Child & Adolescent Behavioral Health
Kate Mattias	Executive Director	National Alliance on Mental Illness Connecticut
Bahar Matusik	Clinical Pharmacy Manager	Waterbury Hospital
Jennifer McGarry	Patient Services Manager	Leukemia and Lymphoma Society
Patricia A. McKinley	Strategic Volunteer to Non-Profit Organizations	Waterbury Health Home Coalition; United Way Greater Waterbury; Connecticut Community Foundation
Kathleen McManamy, LCSW	Regional Supervisor	Connecticut Community Care, Inc.
Kathleen McNamara	Community Resident	
Emmett McSweeney	Library Director	Silas Bronson Library
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Chris Miller	Administrative Fellow	Saint Mary's Hospital

Thomas Missett	Chief Development Officer	Waterbury Hospital
Alan C. Mogridge	Executive Director	Valley YMCA
Peg Molina	Director of Social Services	Town of New Milford
Patrick Morgan	Interim Director Surgical Services	Waterbury Hospital
Drew Morten	Physician Assistant	Connecticut Academy of Physician Assistants
Luci Moschella	Nursing Supervisor	Waterbury Health Department
Lois Mulhern	Nursing Supervisor	Waterbury Health Department
Melanie Nachajska, LCSW		YNA Health Care
James O'Rourke	CEO	Waterbury YMCA
Peggy Panagrossi	Executive Director	Safe Haven of Greater Waterbury
Kim Pernerewski	President	National Alliance on Mental Illness Waterbury
Peter Porrello, MD	Physician	Waterbury Hospital
Pamela Pratt	Manager, OP Behavioral Health	Saint Mary's Hospital
Fenn Quigley	Community Resident	
Ernst Racine, Jr.	Family Center Coordinator/Fatherhood Specialist	Catholic Charities
Loryn Ray, MPH	Director of Elderly Services	Town of Woodbury
Pamela Redmond	Public Affairs Officer	VA Connecticut Healthcare System
Thomas E. Reinahrdt, MD	Chief of Psychiatry	Waterbury Hospital
Laurie Reisman	Director of Operations	Family Services of Greater Waterbury, Inc.
JoAnn Reynolds-Balanda	VP Community Impact	Untied Way of Greater Waterbury
Diane Rokosky, R.N		Public Health Deptartment
P. Russell	Community Resident	
William Rybczyk	Director Research, Development, & Planning	New Opportunities, Inc
Linda Sapio-Longo, APRN	Family Nurse Practitioner	Waterbury Hospital Infectious Disease Clinic
John A. Sarlo	Director	Mattatuck Senior Center, Inc.
Donita Semple	Senior Manager, Performance Improvement	Waterbury Hospital
Loraine Shea	Director	Waterbury Hospital
Frank Sherer	Senior Vice President	Timex Group
Carl Sherter, MD	Chief of Staff	Waterbury Hospital
Catherine Sousa	Supervisor of Patient Transport	Saint Mary's Hospital
Linda Spadaccini	Library Director	Waterbury Hospital
Susan Stauffacher	Chairman	Roxbury Council on Aging
Gary Steck	Chief Executive Officer	Wellmore Behavioral Health
Monica Stokes	Assistant Manager Customer Support	Waterbury Hospital
Christine Thomas-Melly	Benefits Manager	Waterbury Hospital
Donald Thompson	Chief Executive Officer	Staywell Health Center
Joseph M. Tuggle, MD	Physician	Complete Newborn Care, PC
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Kara Vendetti	WIC Program Coordinator	Waterbury Health Department-WIC Program
Deborah Vitarelli	Executive Director	Waterbury Arc, Inc.
Kathy Volz	Practice Manager CFHC	Franklin Medical Group at Saint Mary's Hospital
Chad Wable	President & Chief Executive Officer	Saint Mary's Hospital
Julie Weidemier	Assistant Director	Waterbury Hospital
Claude E. Williams	Executive Director	Mount Olive A.M.E. Zion Senior Citizens Center, Inc.
Jeffrey Williams	Grant Writer	Waterbury Hospital
Eileen Woods	Assistant Director Telemetry	Waterbury Hospital
Kathy Woods	Executive Director	Living in Safe Alternatives, Inc.
D. Woolley	VP Human Resources	Waterbury Hospital
Randy York	Infant Immunization Coordinator	Waterbury Health Department
Mary Zasada	Clinical Informatics Manager	Saint Mary's Hospital
Melissa Zwang	Program Director	New Opportunities, Inc.
Patricia Zuccarelli	Director	Department of Children & Families

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT Q22-2

CHNA IMPLEMENTATION PLAN

Waterbury Hospital

CHNA IMPLEMENTATION STRATEGY

BACKGROUND

Waterbury Hospital was the first hospital in the city of Waterbury and has served the area since 1890. In its first year, Waterbury Hospital served 85 patients and had a staff of 21. It is now licensed for 357 beds and employs more than 2,000 people. The hospital serves approximately 15,000 inpatients, 160,000 outpatients, and 58,000 emergency department visits annually. The mission of Waterbury Hospital is to provide compassionate high quality health care services through a family of professionals and services. The vision of Waterbury Hospital is to be the health care organization of choice by providing superior customer service to patients and physicians.

Waterbury Hospital primarily serves the city of Waterbury and its' surrounding towns. In 2013, Waterbury Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with the Greater Waterbury Health Improvement Partnership. The partnership consists of Waterbury Hospital, Saint Mary's Hospital, Waterbury Department of Public Health, City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Waterbury Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Waterbury Hospital's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs. Waterbury Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA.

THE CHNA PROCESS

A comprehensive CHNA was conducted and included a variety of quantitative and qualitative research components. These components included the following:

1. Secondary Data Profile
2. Statistical Household Survey
3. Focus Groups
4. Key Informant Interviews
5. Prioritization of Identified Community Needs

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Connecticut Department of Public Health, and Centers for Disease Control and Prevention. The information profiles the most recent year health indicators, census figures, household statistics, morbidity and mortality rates, and socioeconomic measures for the city.

A **Statistical Household Survey** was completed with 1,100 community residents. The survey aligns with the Behavioral Risk Factor Surveillance System) study promoted by the Centers for Disease Control and Prevention (CDC). The survey assessed indicators such as general health status, prevention activities (screenings, etc.), and risky behaviors (alcohol use, etc.). The results were examined by a variety of demographic indicators including age and gender. Special attention was given to identifying the needs of underserved individuals, including low-income, minority, and chronic condition populations in the county.

Holleran conducted six **Focus Groups** to better understand health issues related to access to care, health education/communication, healthy behaviors, and community health infrastructure. A total of 24 health care providers and 33 community residents participated in the six focus groups. Holleran analyzed the results of the findings to determine commonalities between populations and uncover themes to aid Waterbury Hospital in addressing the identified barriers.

Key Informant Interviews were collected via an online survey administered by Holleran. A total of 205 community leaders, including public health experts, health and human services providers, and representatives of underserved populations participated in the survey. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived quality of care, key health issues prominent in the community, and quality of life issues.

A **Prioritization Session** was held on June 18, 2013. Approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 CHNA and prioritize key health needs. Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. Please see Appendix A for a listing of individuals who attended the session.

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

In June 2013, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the CHNA data. The planning meeting was initiated and facilitated by the Greater Waterbury Health Improvement Partnership. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives for the day were outlined as follows:

- To review recently compiled community health data and highlight key research findings;
- To initiate discussions around additional key health issues not represented in the CHNA;
- To prioritize the community health needs based on select criteria

Prioritization Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.
Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans.

Master list of community priorities (Presented in alphabetical order.):

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

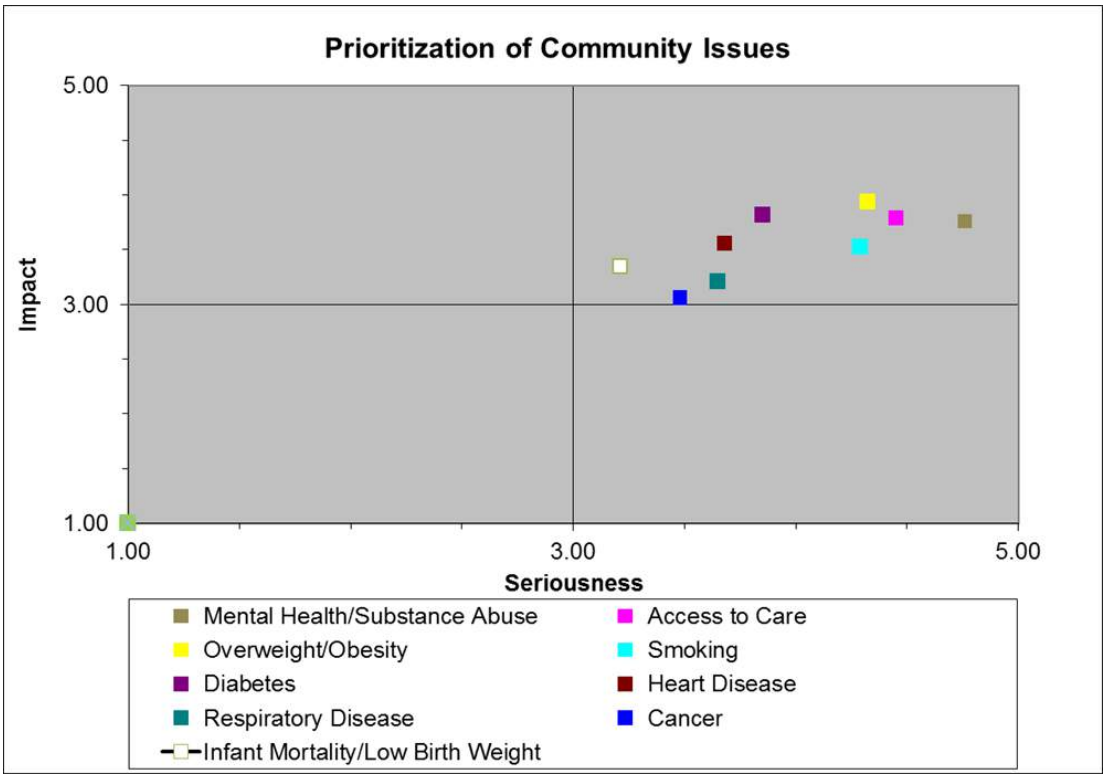
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following five priority areas for Waterbury were adopted:

A. Access to Care
B. Mental Health/Substance Abuse
C. Overweight/Obesity
D. Smoking

WATERBURY HOSPITAL'S STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Waterbury Hospital's Implementation Strategy illustrates the hospital's specific programs and resources that will support ongoing efforts to address the identified community health priorities. This work will be supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, related objectives and strategies, and inventory of existing community assets and resources for each of the four priority areas are listed below.

A. ACCESS TO CARE

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of persons with health insurance
- Increase the proportion of persons who have a specific source of ongoing care
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
- Increase the number of health providers that accept Medicaid and Medicare

Strategies:

1. Increase the number of patients screened and enrolled in insurance programs by WHAP case managers by 10% at the 6 sites in the City of Waterbury by utilizing Certified Assisters to access the CT Health Exchange in response to the Affordable Care Act.

2. Increase the number of patients enrolled in Project Access by 10% for donated, primary and specialty care, reduced prescriptions and Medicare copay assistance, and donated lab and radiology hospital-based services.

3. Provide technical assistance to WHAP sites at St. Mary's Hospital and StayWell Health Center to enable them to track recidivism in the ED for non-emergency codes.

4. Offer 2 onsite bi-lingual medical Spanish classes for 15 clinical staff per class to improve communication with patients.

5. Introduce the CultureVision database to enable healthcare professionals and facilities to provide culturally competent patient care.

Existing Resources:

Underserved Populations
Waterbury Hospital works closely with local healthcare providers and community-based organizations to identify healthcare needs for underserved patients throughout the Waterbury community. Through these collaborations, Waterbury Hospital works to develop key programming for the city's vulnerable populations such as: the Waterbury Hospital Infectious Disease Clinic, which provides comprehensive HIV care to ~500 People Living with HIV/AIDS; and The Waterbury Health Access Program, which provides comprehensive case management services to over 3,000 uninsured and underinsured patients annually; and the Waterbury Hospital Chase Diabetes Disease Management Clinic, is one of the many free clinics offered at Chase Outpatient Center; others include Rheumatology, Surgery, Gastroenterology, Dermatology, Podiatry, and Psychiatry.

During 2012, Waterbury Hospital's spectrum of services continued to have a positive impact on the welfare of Waterbury's citizens. To remain consistent with Waterbury Hospital's mission, many of our services are targeted for vulnerable members of our community, including those who are uninsured or underinsured. In order to provide access to continuing high quality professional health care in the Greater Waterbury area, Waterbury Hospital is a site for 40 clinical programs for new health professionals including: Primary Care Residents, Surgical Residents, Nurses, Physician Assistants, Pharmacy Residents, and Radiology Techs. In addition the Waterbury Hospital Youth Pipeline Initiatives target the emerging workforce in area elementary, middle and high schools.

Health Professions Education

Yale Primary Care Internal Medicine Residency Program
During 2012, our Yale Primary Care Internal Medicine Resident activities included:

- Participation in research days at Yale and Waterbury/St. Mary's Hospitals;
- ACP regional and national meetings;
- The annual Health Fair held at the Waterbury YMCA;
- Home/office visits for clinic patients; and
- Educational seminars held at Waterbury Hospital and Yale University.

At Waterbury Hospital, we seek to train physicians who desire a generalist background to their careers in medicine. This program is unique in that it provides the medical residents the opportunity to work each year in a tertiary medical center at Yale-New Haven Hospital, a community hospital at Waterbury Hospital, and outpatient practice sites that include private practice offices and community health centers is unique in residency training. Our graduates are

highly sought after by private practice offices, hospitalist programs, and fellowship programs throughout the country.

Student Nurse Intern Program (SNI)
The SNI program is available for nursing students entering their senior year. The program provides these student nurses with shadowing opportunities so they can apply their content knowledge to authentic patient care situations. Staff RNs serve as the students' mentors as the students accompany them on their medical rounds. The goals of the program are: (1) to provide the student nurses with the knowledge and skills necessary to pass the NCLEX exam and (2) to socialize the student nurse in an attempt to decrease the stress of assimilating into the hospital's work environment, should they be hired as Graduate Nurses at Waterbury Hospital.

Physician's Assistant (PA) Students
P.A. students from Quinnipiac University completed clinical rounds in several departments around the hospital, including the Operating Room, Emergency Department, Behavioral Health, and Radiology. The experience is designed for the student to learn to apply the knowledge gained from didactic course work in medicine, surgery, and the basic and behavioral sciences into the clinical arena resulting in the ability to successfully manage patients in a thorough and comprehensive manner. The primary goal of clinical rotations is to expose the student to patients of all ages, patients in a variety of different settings, and patients with a broad range of medical, surgical, and psychosocial problems.

The P.A. students participate in:

- History taking;
- Examining the patient;
- Assisting in and/or performing diagnostic testing;
- Assisting in and/or performing therapeutic tasks;
- Oral presentations;
- Medical documentation of the patient encounter;
- Formulating a differential diagnosis and problem list;
- Formulating a treatment plan; and
- Counseling of patients regarding medication, diet, and lifestyle changes such as smoking cessation, exercise, and well-being.

Radiology Students from NVCC
The Naugatuck Valley Community College (NVCC) Radiology students are involved with many activities while assigned to Waterbury Hospital. Under the supervision of a NVCC clinical instructor and hospital radiologic technologists, the students are assigned to the various radiographic suites and modalities. During their assignment, students are performing or assisting with radiographic procedures, including chest x-rays, skeletal exams, fluoroscopic procedures, mobile x-rays in the various patient units, and surgical cases. The students also increase the number of individuals available in the department to assist in moving and transporting patients as well as chaperoning sensitive exams. In addition to the diagnostic

radiology the students are assigned to experiences in Interventional Radiology, CT, MRI, Nuclear Medicine, and Ultrasound. Students work in these modalities under the direct supervision of the hospital staff.

Waterbury Hospital's affiliation with NVCC as a clinical site for students has many benefits. Perhaps the single most important benefit is the hospital has a continuous stream of potential radiology employees. Students are in the program for 22 months and in that time become very familiar with the hospital equipment, routines, personal, and mission. This provides Waterbury Hospital with new employees who have a strong skill set and proven dedication to the hospital community.

Waterbury Hospital Youth Pipeline Initiatives

The Waterbury Hospital Youth Pipeline Initiatives were established in 2001 as a partnership between Waterbury Hospital and Waterbury Public Schools. The mission of the program is: "to close the achievement gap for minority and economically disadvantaged students in Waterbury so they can matriculate and compete nationally for placement in post-secondary education programs in preparation for health careers". Waterbury Hospital is committed to enhancing and enriching the academic opportunities and personal journeys of our youth, who are the emerging workforce of tomorrow. To this end, during 2012, Waterbury Hospital continued to provide 383 students and parents in Greater Waterbury with unique educational programs that will enhance the overall welfare of our community. The WH Youth Pipeline Initiatives had four focus areas during FY 2012, including:

Providing Early Acquaintance with Careers in Healthcare (PEACH)

Since its inception in 2004, Waterbury Hospital's Providing Early Acquaintance with Careers in Healthcare (PEACH) Program has engaged administrators, teachers, and students at Waterbury's North End Middle School and West Side Middle School to address projected shortages of healthcare workers and to close the achievement gap for students in Waterbury Public Schools. Through the PEACH Program, students engage with healthcare workers in a non-emergency setting and are informed of the variety of healthcare career opportunities available in our community. Each spring, approximately 100 seventh graders from Waterbury take part in a day-long PEACH tour at Waterbury Hospital, during which they visit at least six hospital departments and complete hands-on learning activities with hospital staff. Annually, Waterbury Hospital also offers its PEACH Spring Break Exploration Camp, this year 38 middle school students from Waterbury took part in: shadowing and hands-on learning activities at the hospital; CPR certification; and educational sessions at Bridgeport's Discovery Museum.

Parent Leadership Training Institute (PLTI)

In 2012, twenty four individuals from Greater Waterbury successfully completed Waterbury's PLTI, a 20-week curriculum teaching leadership and advocacy skills. Waterbury Hospital has hosted the Waterbury PLTI since 2000, and the program has trained and graduated over 175 area parents. PLTI's core mission is to impart leadership and advocacy skills to parents while simultaneously educating them about volunteerism, civic life, and the process by which state

and local governments enact and change laws. Each participant completes and implements a community project; examples of projects from 2012 include: a "High School Driving Education" program (a City-wide initiative to introduce safe driving techniques in high schools) and "The C.H.I.P. Forum" (Children Having Involved Parents—a series of workshops to underline the importance of giving encouragement and support to our children so they can succeed in life).

Parents Supporting Educational Excellence (PSEE)
In 2012, twenty-one individuals from Greater Waterbury successfully completed Waterbury's PSEE, a 13-week curriculum co-created by the Connecticut Center for School Change and the Connecticut Commission on Children for parents (defined broadly as parents, guardians, family members and grandparents) to instill leadership skills in education and to facilitate partnerships between school staff and parents to improve student learning.

WH Summer Bridge Program
During the summer of 2012, twenty-eight students from Waterbury, grades 6-11, participated in the WH Summer Bridge Program. 100% of meals were secured for the program from City of Waterbury Summer Food Program and 8 local restaurants/businesses. Students completed the following modules:

- 78.5 hours of Academic preparation
- 15 hours of job shadowing sessions (Radiology, Nuclear Medicine, Nursing, MRI, Case Management, Dr. S. Aronin (ID Inpatient Rounding), ICU Medical Rounds, Health Information Management, Access Rehab, Behavioral Health, Respiratory Therapy, Finance, WH ID Clinic, Security, Orthopedics, Pharmacy, Infection Control and Surgery.
- 14 hours of Photography instruction
- 4 hours of computer sessions
- 2 full-day field trips completed: one to Yale University for an admissions info session and campus tour and one to Hammonasset State Park including three educational sessions at Meigs Point Nature Center
- 3 hours of healthcare career searches
- 3 hours of college admissions presentations completed by UCONN Waterbury & Yale ROTC
- 1 hour of individual academic advising
- 2 hours of team building activities
- 2 hours of health topics presentations completed, including HIV 101 and Healthcare Jeopardy.

Waterbury Health Access Program
Waterbury Hospital is aware of the economic needs many patients in our community, and, as a result, we remain committed to the Waterbury Health Access Program. Founded in 2003 as a partnership between Waterbury Hospital, St. Mary's Hospital, StayWell Health Center (FQHC), and the Waterbury Health Department, the Waterbury Health Access Program improves access to high-quality medical care by providing comprehensive case management, pharmacy

assistance, and access to primary and sub-specialty medical care for the uninsured and underinsured residents of the Greater Waterbury region. During FY 2012, the Waterbury Health Access Program had over 4,700 active clients. Additionally, Waterbury Hospital provided $784,879 worth of donated services to WHAP's patients.

Waterbury Hospital Infectious Disease Clinic (WHIC)
The WHIC offers a comprehensive "one-stop shopping" model that provides patients with on-site primary and specialty services, medical case management, individualized medication adherence services, mental health and substance abuse services, nutrition counseling, individualized HIV education, laboratory testing, and radiology services. WHIC's providers include three board-certified/board-eligible Infectious Disease specialists as well as an Advanced Practitioner Nurse and a Registered Dietician, all with expertise in the management of patients with HIV/AIDS. In FY 2012, WHIC served around 500 People Living with HIV/AIDS (PLWHA).

WHIC's staff members actively participate in statewide and area collaboratives, such as the Connecticut HIV Planning Consortium (CHPC) and the Ryan White Part A Planning Council, and WHIC facilitates the Greater Waterbury HIV Consortium. WHIC has a very active Consumer Advisory Group (CAG), which organizes social and testing events for the community and facilitates the Waterbury Hospital Photography Group.

The WHIC also has a Hepatitis C clinic, run by an Advanced Practitioner Nurse. From October 2004 to Present, nearly 200 Hepatitis C mono- and co-infected (Hepatitis C and HIV) patients have been evaluated at the ID Clinic. The Hepatitis C clinic provides a consultation with a nutritionist to advise on healthy eating; coordination with mental health services; and educational sessions on side effect management, the importance of hydration and adherence, and positive coping strategies.

Be Well Bus
In order to ensure that patients have access to medical appointments, at the hospital and at local physicians' offices, Waterbury Hospital's Be Well Bus provides transportation services to patients from Waterbury and eleven of its surrounding towns. During FY 2012, the Be Well Bus completed over 4,170 transports to and from medical appointments. Waterbury Hospital has contracted with a transportation provide to offer the bus service, and area providers pay a small fee to participate.

Diabetes Disease Management (DDM) Clinic
The DDM utilizes a multidisciplinary case management approach to develop treatment plans and monitor patient progress. The DDM Clinic provides >150 diabetics with self-management skills and clinical care. The clinical team meets weekly on Wednesdays to develop treatment plans for new patients and collaborate on the progress of existing patients.

Evergreen 50 Club
Waterbury Hospital's Evergreen 50 Club is an organization comprised of over 15,000 members over the age of 50. The Club offers wellness programming, Medicare counseling, and health education presentations on a variety of topics are presented by health care professionals. Presentation topics include: holistic health, varicose vein treatment, heart disease, summer skin care, weight loss, blood pressure, bladder screenings, joint care and replacement, nutrition, and resolving adverse outcomes with patients and families. Annually, the Evergreen 50 Club hosts a health fair for its members, which provides free flu shots and healthcare screenings.

Family Birthing Center
Providing a child-centered focus, Waterbury Hospital's Family Birthing Center offers expectant parents a variety of classes to prepare them for their baby's arrival. Between breast feeding, childbirth, infant care classes, and nutritional presentations at our Family Birthing Center provided vital instruction to over 120 persons last year.

Heart Center of Greater Waterbury
Formed in collaboration with Saint Mary's Hospital, the Heart Center of Greater Waterbury provides diverse medical support initiatives to help educate residents in the Greater Waterbury community about pertinent health and wellness issues. This past year, the Heart Center conducted a series of health fairs and various health and wellness education sessions, including "Ask the Nurse," which provides patients with complimentary blood pressure screenings and health awareness education and a "Freedom from Smoking" series to help our residents kick the habit. During FY 2012, the Heart Center's programs served over 3,280 residents from the Greater Waterbury Area.

Thank God I'm Female
For the past 20 years, Waterbury Hospital's "Thank God I'm Female" has served as an annual women's wellness forum that features 40 educational booths and health-related giveaways. The ultimate goal of the forum is to educate attendees about stress, mental well-being, heart health, diet, healthy cooking, osteoporosis and bone health, change of life, and more. In 2012, over 400 area residents attended the event.

Waterbury Research Day
Through collaboration with St. Mary's Hospital in Waterbury, CT, Waterbury Hospital hosted its annual Waterbury Research Day. During the day, resident physicians, pharmacy residents, and medical students present research projects to the physician community. High school students are also encouraged to participate in the activities.

B. MENTAL HEALTH AND SUBSTANCE ABUSE

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase the proportion of adults with mental health disorders and/or substance abuse who receive treatment
- Increase mental health and substance abuse screening by primary care providers
- Increase cultural competency among mental health and substance abuse providers
- Increase number of points of access for referral to services
- Reduce stigma of mental health and substance abuse disorders
- Increase community support structures and individual resiliency skills
- Increase the proportion of adolescents never using substances
- Reduce illegal substance use

Strategies:

1. Establish bi-annual education/family support seminars which would be available to clients, families and community members.

2. Expand student/intern program to provide clinical training rotations throughout the Department of Behavioral Health. Up to 5 academic year internships would be offered annually to master's level students pursuing education in addictions and mental health.

3. Initiate specialized programming on the inpatient adolescent unit to incorporate Dialectical Behavior Therapy (DBT) skills as well as goal setting to decrease the rates of seclusion and restraint.

4. Maximize resources within the Access Center to increase number of individuals served by 10% by providing assistance and "bridge" treatment to ensure continuity of care between services, and urgent/emergent assistance where needed to prevent decompensation and unnecessary hospitalization.

Existing Resources:

Behavioral Health

Waterbury Hospital's Behavioral Health Department is one of the region's largest service providers offering a full continuum of care for children, adolescents and adults. Our services also outreach to the community through regular participation in health fairs, elected membership in the Northwest Regional Mental Health Board, as a host site to numerous twelve-step meetings and the provision of case management as well as acute services to the homeless within the City of Waterbury.

Grandview Adult Behavioral Health
Grandview Adult Behavioral Health is the adult component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals ages eighteen and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; gender specific programming, cognitive therapy and DBT (Dialectical Behavior Therapy). Services provided in the Intensive Outpatient and traditional Outpatient Programs include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy

West Main Behavioral Health
West Main Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age eighteen and up who suffer from a variety of substance use disorders as well as concurrent psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; motivational interviewing, cognitive therapies and suboxone induction/maintenance.

Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, ambulatory detoxification, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, family therapy and multifamily therapy are also provided when clinically indicated. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Center for Geropsychiatry
The Center for Geropsychiatry is one of the adult components of the Behavioral Health Department ambulatory care service. Comprehensive psychiatric treatment is offered to individuals age sixty and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.

Services provided in the Outpatient Program include comprehensive psycho diagnostic assessment and evaluation, family therapy, group therapy, milieu therapy, and pharmacotherapy. Individual and Family Therapy is provided as needed.

Child and Adolescent Behavioral Health
Child and Adolescent Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age ten to eighteen who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders.

Limited outpatient services are provided to individuals aged 12-21 who are transitioning to outpatient and/or adult services. Intensive ambulatory services are organized to promote recovery from psychiatric disorders through active treatment outside of an inpatient setting. Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are also provided when clinically indicated. Transportation services are available to patients for partial hospital visits as needed. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Services provided in the Intensive Outpatient Program and Outpatient Service include comprehensive psycho diagnostic assessment and evaluation; group therapy; milieu therapy; and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are provided when clinically indicated.

Crisis Center/ Access Center

The Crisis Center provides urgent/emergent evaluations and short term treatment to all individuals presenting to the Emergency Department and/or Crisis offices with immediate and acute behavioral health needs. Consultation services are provides on the inpatient medical floors when ordered by an attending physician. Evaluative services are provided for any individual regardless of their age.

Services are provided to individuals who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, substance use disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.
Active collaboration and coordination of care occur with the patients, the crisis clinicians and community provides to ensure a smooth transition from crisis services to the next appropriate treatment setting.

Program hours are Seven days per week between 8 am and midnight. Services are open and available 365 days per year.

Center for Behavioral Health

Behavioral Health Services provided include psychiatric evaluations, OT/AT evaluations, family therapy, group therapy, didactic educational groups, individual counseling and recreational services all within a milieu framework offering twenty four hours services within an inpatient hospital setting. Inpatient services are available within separate subunits to adolescents (ages 12- 18) as well as adults age 18 and over. Diagnostic services are available when indicated within the general hospital and include clinical laboratory, radiology and medical/service allowing for comprehensive consultations.

Our efforts are aimed at promoting the benefits of clinical treatment as well as positive lifestyle choices. Every effort is made to educate clients, their families and the community about mental

illness and the impact treatment can have on one's illness. The ultimate goal is to help people feel better, reduce or resolve symptoms and to minimize the stigma of mental illness.

Support Groups
During 2012, Waterbury Hospital hosted several support groups for its patients and their families, including:

- Behavioral Health's parent and sibling support group, which offers emotional assistance to families who have children in treatment; and
- Alcoholics Anonymous, serves over 4,000 people annually, meets weekly throughout the year, and is coordinated by our Behavioral Health Department.

C. OVERWEIGHT AND OBESITY

Goal: Promote health and reduce chronic disease through healthy(ful) eating and physical activity

Objectives:

- Reduce percent of overweight and obese residents
- Increase access and consumption of healthy foods
- Increase food security by addressing/reducing hunger
- Increase access to and use of safe areas for physical activity
- Increase residents knowledge/awareness of a balanced diet and physical activity
- Reduce risk factors for chronic disease

Strategies:

1. The WH Wellness Committee initiates events and activities focused at supporting the physical and mental wellbeing of the WH staff and residents in the county. Initiatives include: (1) Establish a weekly Farmer's Market in conjunction with Waterbury's Brass City Harvest on Hospital grounds to increase access to and encourage consumption of healthful foods. (2) Establish a "Get Moving" program to encourage physical fitness for employees, patients, and community members.

2. Increase nutritional education within the child and adolescent Behavioral Health program as well as the implementation of a "low ropes" program to increase self-awareness, skill building, and physical fitness.

3. Increase the number of patients receiving nutritional counseling and self-management education at WH ID Clinic, and WH DDM Clinic by 10%. Referrals to the WH outpatient dietitian are made when clinically indicated.
4. Publish calorie counts for all foods in the WH Cafeteria by December 2014.

5. Conduct an employee health risk assessment in January 2015 to 100% of WH employees with health insurance through WH to encourage positive health engagement with a discount deductible incentive.

6. Expand the physical fitness program in collaboration with the Waterbury YMCA at the DDM Clinic to include 20 patients of the WH ID Clinic.

Existing Resources:

Nutritional Counseling
Patients admitted to WH (inpatient) are screened within 24 hours to assess for nutrition risk; those patients that are at high nutrition risk trigger a consult to the Registered Dietitian. MDs and other providers can order an RD consult for any patient they feel should be seen by an RD (including diet education). In addition, all patients of WH DDM Clinic and WH ID Clinic are seen by a Registered Dietitian and are provided with appropriate nutritional counseling and self-management training. Patients at both clinics are seen as often as necessary to teach nutrition concepts and help them to make desired lifestyle changes; these patients are seen at least annually.

Supporting Community Need
The WH ID Clinic runs a Food Pantry for HIV patients. WH also routinely responds to requests from the community through organized campaigns for specific items run by its employees ie the annual Thanksgiving Turkey drive in November and the annual Cereal drive in May, to help families prepare to feed children breakfast during the summer months when school is out.

Patient Fitness
The DDM Clinic has established an established an arrangement with the Greater Waterbury YMCA to provide monthly memberships to DDM patients to promote a regular exercise regime; 21 patients were referred from January through November 2012.

Employee Fitness
WH maintains an onsite Fitness Center for employee use, open 24 hours a day, seven days a week. Employees pay a one-time, $10 life-time membership fee. WH employees also receive a discount on Waterbury YMCA memberships. Additionally, WH supports on-line participation in Weight Watchers programs for its employees.

Community Fitness
The Evergreen 50 Club offers multiple 'keep fit' programs for community members and staff over 50 years old. Classes include Pilates and weight training.

D. TOBACCO USE

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

- Reduce smoking and overall tobacco use among adults, adolescents and children
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation attempts and recent successes by smokers
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase tobacco free environments

Strategies:

1. Provide tobacco screening to 100% of patients and education to 100% of patients who smoke before their discharge from WH.
2. Increase tobacco screening and education to 100% of outpatients seen in the primary care medical practice for continuity visits at the Chase Outpatient Center. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
3. Screen 100% of patients in the WH ID Clinic for tobacco use. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
4. Participate in the American Lung Foundation's annual 'Great American Smoke Out' program through the WH Wellness Committee.

Existing Resources:

WH successfully transitioned to a Tobacco free campus in November 2010.

Tobacco screening is provided to 100% of patients in the WH Behavioral Health Department and education is provided to 100% of patients who tobacco users. Resource information on smoking cessation is provided in all patient waiting areas.

WH is collaborating with the Regional Mental Health Board and will be providing smoking cessation groups along with one to one telephonic coaching.

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Waterbury Hospital plans to address all four of the prioritized community health needs identified through the 2013 Community Health Needs Assessment and prioritized by community representatives.

APPROVAL FROM GOVERNING BODY

The Waterbury Hospital Board of Directors met on September 26, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the **2013 Waterbury CHNA Final Report**, the **2013 CHNA WH Implementation Plan**, and the **2013 CHNA WH Implementation Plan Summary**, and provide the necessary resources and support to carry out the initiatives therein.

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT Q25-1

CURRICULUM VITAE/BIOGRAPHICAL PROFILES: GWHN

DARLENE STROMSTAD, FACHE
President and Chief Executive Officer

Darlene Stromstad assumed leadership of Waterbury Hospital in July 2011 after serving as President and CEO of Goodall Hospital in Sanford, Maine, for six years. Prior to that, she was Senior Vice President at Catholic Medical Center in Manchester, N.H., and Vice President at St. Joseph's Healthcare in Nashua, N.H. Last year, she was elected to the national Board of Governors of the American College of Healthcare Executives, and is a past board member of the Maine Hospital Association, the York County United Way, and has chaired the American Heart Association's Red Dress Campaign for York County. She is a native of North Dakota who received her BA from the University of North Dakota, Grand Forks, and her MBA from Rivier College in Nashua, N.H.

Michael Cemeno, VP and CIO

Mike joined us in 2012 and is a nationally recognized CIO who has led Waterbury Hospital to 3 consecutive Most Wired Awards. He is responsible for IT, Telecom, Clinical Engineering and Facilities. Over the last 3 years his team was responsible for implementation of CPOE, Nursing Documentation, and now Physician Documentation moving the hospital from HIMSS Level 4 to HIMSS Level 6. We also achieved MU II certification in the same time frame. Barcode Med Administration and Medical Device Integration are just two areas of IT that were implemented for enhanced patient safety.

Mike was the Associate CIO for Yale New Haven Health System for the previous 8 years and CIO of a 4 hospital system (Greater Hudson Valley Health System) in Mid-State New York for 5 years prior to that. Mike has a BBA from Temple University.

David J. Pizzuto, M.D. - Vice President of Medical Affairs/CMO

Dr. Pizzuto became the Vice President of Medical Affairs/CMO in June 2011. A graduate of The Waterbury Hospital Internal Medicine Residency Program (1987), he has been a member of the Attending Medical Staff since January 1988. In addition to his administrative duties, Dr. Pizzuto also continues to practice Internal Medicine full time. Additionally, Dr. Pizzuto has held various leadership roles at Waterbury Hospital including Chairman Department of Medicine (1997-2007), Chief of Staff (2008-2010), and member of the Board of Trustees (2011 – present).

Dr. Pizzuto holds an M.D. from New York Medical College (1984), a Master of Science from the University of Minnesota (1980), and a Bachelor of Science from the University of Connecticut (1977). He is certified by the American Board of Internal Medicine (1996 and 2006 –recertified).

MARK HOLTZ, MS, FACHE

Mark Holtz is Currently Senior Vice President and Chief Operating Officer of the Greater Waterbury Health Network in Waterbury Connecticut. In this role, Mark's current responsibilities are for Patient Care Services, Contracted Services, Hospital Outpatient Services, Laboratory, Pharmacy, Alliance Medical group, and the Cardiology Service line including the Cardiology Associates of Greater Waterbury. Mark's prior positions include, SVP/COO of Glens Falls Hospital in NY, COO of Overlook Medical Center which is part of the Atlantic Health System, and SVP of Operations for Lehigh Valley Health Network. Mark received his Bachelor of Arts in Psychology from Herbert H. Lehman College of the City University of New York in 1979, and Master of Science in Healthcare Systems Management from Iona College in New Rochelle NY in 1984. Mark is also a Fellow of the American College of Healthcare Executives.

James Moylan
Interim Chief Financial Officer

Jim has spent his entire 43year professional career in healthcare finance in CT. Currently he is self- employed as a consultant and interim executive manager. In 2012 he retired from Griffin Hospital as its CFO for 12 years and prior to that was the CFO of Bristol Hospital for 14 years. He received his bachelor's degree from Bentley University, and his masters from Rensselaer-Hartford.

John Camus

Current:
Vice President Physician Practices
Alliance Medical Group / Waterbury Hospital

Previous Experience:
Vice President Operations
Delphi Of TeamHealth
Vice President Physician Services
Mountainside Hackensack UMC
Director Physician Practice
Newport Hospital
Chief Executive Officer
Olean Medical Group
Vice President Operations
Hampden County Physician Associates
Vice President Operations
RiverBend Medical Group

Education:
Western New England University - MBA
University of Massachusetts - BA Japanese Language
Assumption College - BA Sociology

Sandra A. Iadarola, RN, MBA, CPHQ
Chief Nursing Officer/Vice President of Patient Care Services

Sandra had worked in this role since early 2011. She has operational accountability for 38 departments, including all inpatient and several outpatient services. These include Behavioral Health, Critical Care services, Family Care services and Surgical services. She oversees all Nursing functions within the organization. She has also serves as Chairperson of the Board of Directors for our affiliate, the VNA Health at Home. From 2002 to 2011, Sandra was the Administrative Director of Med/Surg and Critical Care Services at Waterbury Hospital. She served as the implementation project lead for the initiation of the open heart surgery program and as the clinical transformation lead for the electronic medical treatment record implementation. Prior to 2002, Sandra was the Vice President for Patient Care Services at Charlotte Hungerford Hospital in Torrington, CT.

Dr. Richard P Kropp, Ed.D. SPHR, SHRM-SCP
Principal Consultant

Dr. Kropp is Vice President for Human Resources for Waterbury Hospital and has been a principal consultant at The Kropp Group, a full-service management consultancy servicing an international client base. He has also been also affiliated with NRS Global Partners which is a search and technology consulting firm. Dr. Kropp is a human resource and organizational development executive with extensive success in the comprehensive leadership of large human resource organizations.

He has proven success in the conceptualization, implementation and administration of corporate universities. Dr. Kropp has demonstrated expertise in business, analytical, and negotiation skills. In addition, he is a motivational team leader with a track record of effectively leading and managing organizations of one to more than a hundred members. He has also published several books on such subjects as team building, team leadership, and business communication

He has also served as the Chief Human Resource Officer for Cape Cod Healthcare, Steward Healthcare, and Lourdes Health System.

Dr. Kropp has consulted and trained for companies in the health care, finance, high tech and educational fields on the design and implementation of human resource management systems. He has progressive experience in line and staff management, project management, organization development and sales telemarketing education. Dr. Kropp spent ten years in various training and organizational development positions at Wang Labs, where he created and implemented programs to select, develop, and appraise the top 300 managers, developed Executive Compensation and Succession Management Systems, and developed corporate-wide selection processes.

He has also held training management positions at the First National Bank of Boston and The Bell Telephone Company of Pennsylvania. In addition, he developed and facilitated open enrollment and on-site programs in project management, management development and continuous improvement for Boston University Corporate Education Center. Dr. Kropp has also served as a Program Manager/Facilitator for a service excellence standards program implemented by General Motors at hundreds of automotive dealerships in the United States.

Education:

He earned his doctoral in Industrial and Humanistic Psychology from Boston University. He holds a Bachelor's degree from the Mansfield University of Pennsylvania and a Masters in Human Resources from The Pennsylvania State University.

Publications

"Team Workout," HRD Press, 2008.
"Human Resource Planning & Development in Healthcare" in "Best Practices in Human Resource Management," Jossey-Bass, 2006.
"Self-Directed Teams," HRD Press, 2001.
"New Teams," HRD Press, 2000.
"50 Activities for Team Building," HRD Press, 1999.
"Performance Management and Collaborative Leadership," AMS Press, 1998.
"Communicating in the Business Environment," HRD Press, 1993.

Presentations:

Work-Life Balance; a presentation at the 2015 CIO conference at Boston; March 2015

The Current State of the Healthcare Industry and its Impact on Human Resource Management; a presentation to the CHE/Trinity Healthcare Human Resource Community. Philadelphia; June 2014

360 Evaluations and the Principle of Followership; a presentation to the CHE/Trinity Healthcare Human Resource Community. Philadelphia; April 2013

Critical Thinking for Human Resource Professionals; a workshop for the JPMorgan Human Resource Community. Wilmington, Del. August 2013

Employment Law and the Supervisor; NRS Global Partners Associates Meeting, August 2012. Boston, MA

Leadership in the Ever Changing Healthcare World; Lourdes Health System Annual Leadership Meeting, Keynote Address; June 11, 2011, Camden, NJ.

Human Resource Issues in Higher Education: A Guided Conversation with the Search Committee for the System Chief Human Resource Officer for The University System of New Hampshire; June 2011

Setting the Standards for On-line Learning; ITI Conference January 2009. Boston, MA

Creating a Corporate University, The 2008 Talent Management Conference, Orlando, March 2008.

Defined Contribution Plans in the Healthcare Setting; a speech to the Lincoln Financial client conference at Philadelphia; November, 2005

Closing the RN gap through Community College and Healthcare System Collaboration, DOL National Conference on Innovations for the Incumbent Workforce, Philadelphia, June, 2005.

Developing the Healthcare Workforce, National Workforce Investment Board Conference, Washington, DC, February, 2005.

Human Resource Planning in Healthcare; A speech to the Health Information Conference of VA, September, 2002.

The Leader Manager in Healthcare, Linkage OD Conference, Naples, FL and Chicago, IL, 2000.

Patricia Gentil, MS, RHIA, CHC

Patricia Gentil is the Compliance and Privacy Officer at Waterbury Hospital. Patricia is responsible for the compliance program and compliance reporting systems. She is also responsible for the specific policies and procedures related to corporate compliance and HIPAA privacy. In addition she is responsible for the compliance committee and manages regulatory compliance audits, as well as conducts compliance and Privacy investigations. Patricia also oversees the HIM and Case Management Departments. She plays a key role in revenue cycle management and most recently has led the ICD-10 implementation efforts at Waterbury Hospital. Patricia is certified in Healthcare Compliance through the CCB and is also certified as an RHIA through AHIMA.

EXHIBIT Q25-2

PMH BIOGRAPHICAL PROFILES

RESPONSE TO QUESTION #25
BIOGRAPHICAL SUMMARIES

Sam Lee is Chairman of the Board of Directors and Chief Executive Officer ("CEO") of Prospect Medical Holdings, Inc. ("PMH"). Mr. Lee was appointed as PMH's CEO on March 19, 2008 and as Chairman of PMH's board of directors on May 14, 2008. Mr. Lee was previously appointed as a member of PMH's board of directors and as CEO of Alta Hospitals System, LLC ("Alta Hospitals"), the current corporate hospital segment and a subsidiary of PMH, on August 8, 2007. In 1998, Mr. Lee co-founded Alta Hospitals (formerly Alta Healthcare System, Inc.) with David Topper (see below) after acquiring seven (7) Los Angeles area hospitals from Paracelsus Healthcare Corporation ("Paracelsus"). Previously, he served as the President of Alta Hospitals from January 2002 until PMH acquired Alta Hospitals. Mr. Lee's background involves healthcare and technology related private equity investment management, operational leadership, entrepreneurship, mergers and acquisitions, and leveraged financing for various corporations. Prior to joining Alta Hospitals, Mr. Lee was a General Partner with Oline Hawkes & Co., a $500 million private equity firm located in Brentwood, California, that focuses on healthcare, technology, and business services.

David Topper is President of Alta Hospitals, a position he has served since 2007. He previously served as Alta Hospitals' CEO and a member of its Board of Directors between 1998 and 2007. In 1998, Mr. Topper co-founded Alta Hospitals with Mr. Lee. Prior to his involvement with Alta Hospitals, Mr. Topper served as Senior Vice President of Development and Hospital Operations for Paracelsus. Additionally, Mr. Topper has held healthcare executive management positions as a Hospital Administrator with Ramada Medical Corporation and as a Regional Vice President with Community Psychiatric Centers.

Dr. Mitchell Lew is President of PMH. Previously, Dr. Lew served as CEO of PMS since May 2012 and as the designated physician shareholder since February 1, 2013. He served as the Chief Medical Officer for PMS from December 2008 through December 2012. Prior to joining PMS, Dr. Lew was the CEO of Genesis HealthCare of Southern California, Inc. ("Genesis") from 1999 to 2006. In November 2005, Genesis was acquired by a company affiliated with PMS. From 1991 to 2001, Dr. Lew was the President of Lew Medical Group Inc., a medical group in which he also maintained a medical practice specializing in General Obstetrics and Gynecology.

Stephen O'Dell is Senior Vice President, Coordinated Regional Care for PMH. In this role, Mr. O'Dell leads the Company in its efforts to integrated our regional delivery systems among physicians, hospitals and payors. He is responsible for the development, implementation and oversight of the Company's coordinated regional care delivery systems in each of its regional markets. Prior to joining PMH, Mr. O'Dell served as Senior Vice President, Growth and Corporate Development, at Molina Healthcare. Before that, Mr. O'Dell held managed care senior executive positions with Blue Cross Blue Shield, United Healthcare, FHP International and First Consulting Group.

Steven Aleman is Chief Financial Officer of PMH, a position he has held since 2013. Prior to that appointment, Mr. Aleman, who is a certified public accountant, served as PMH's Vice President, Finance and Development since August 2010. Between May 2009 and July 2010, Mr. Aleman served as the CFO of SCH at Culver City, formerly known as Brotman Medical Center, Inc., a hospital subsidiary of PMH. From July 2008 through April 2009, Mr. Aleman held the position of Vice President of Internal Audit at PMH. Between 1998 and 2008, Mr. Aleman served in several positions ending as the Staff Vice President of Compliance with Wellpoint, Inc.

Ellen Shin, Esq. is General Counsel and Secretary of PMH, a position she has held since 2008. Ms. Shin is responsible for overseeing the legal and regulatory affairs of PMH and its affiliates, including corporate governance, regulatory compliance, litigation, transactions, government affairs and public policy activities. Prior to serving in her current position, Ms. Shin was the General Counsel and Secretary of Alta Hospitals from June 2006 to March 2008, where she oversaw the sale of Alta Hospitals to PMH. Prior to joining Alta, Ms. Shin was in private practice at several national and regional law firms in Los Angeles, California.

Cindra Syverson is Senior Vice President, Chief Human Resources Officer. Previously, Ms. Syverson spent seven years with Seattle-based Providence Health System as the corporate SVP, Chief Human Resources Officer. She also was the principle consultant of Syverson Consulting, Inc., which supported organi□ations talent and success management strategies, human resource operations improvement, culture change management and employee engagement and labor relations strategies. She has also held senior executive human resources positions with St. Joseph Health System, and PacifcCare□FHP.

Von Crockett is Senior Vice President, Corporate Development of PMH. Prior to that appointment, Mr. Crockett served as the Chief Executive Officer of SCH at Culver City from 2009 to 2012. Prior to joining SCH at Culver City, Mr. Crockett was the President and Chief Executive Officer, beginning in 2007, of Centinela Hospital Medical Center, a hospital with 369 licensed beds, 500 affiliated physicians, 1,500 staff and □260 Million annual net revenue, located in Los Angeles, California. From 2004 into 2007, Mr. Crockett served as the System Chief Operating Officer of Centinela Freeman Health System in Los Angeles, California. Between 2002 and 2004, he served first as the Chief Operating Officer and then the Chief Executive Officer for Doctors Medical Center San-Pablo□Pinole in San Pablo, California. He also served as the Chief Financial Officer of Sutter Healthcare, in Antioch, California, and Sharp Healthcare Corporation, in San Diego, California, from 2000 through 2002 and 1991-1999, respectively. Prior to those positions, he served in several finance related positions within the industry.

Hoyt Sze is Vice President, Chief Compliance Officer and Privacy Officer for PMH. Mr. S□e oversees and manages the compliance and privacy programs for the Company and its affiliates. Previously, Mr. S□e was a partner at McDermott Will & Emery LLP, a deputy

federal public defender at the Office of the Federal Public Defender and an associate at Latham & Watkins.

EXHIBIT Q37-1

FINANCIAL WORKSHEET (C) FOR THE HOSPITAL ONLY, AND FOR GWHN AND PMH WITHOUT THE CON PROJECT (columns 1,2,5,8 &11), WITH THE CON PROJECT AND INCREMENTAL TO THE CON PROJECT (remainder columns)

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Greater Waterbury Health Network

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 15 Projected**	**FY 16 Projected**	**FY 16 Projected**	**FY 16 Projected**	**FY 17 Projected**	**FY 17 Projected**	**FY 17 Projected**	**FY 18 Projected**	**FY 18 Projected**	**FY 18 Projected**
	Description	**W/out CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**										
1	Total Gross Patient Revenue	$1,000,485,065	$1,006,038,550	$12,320,599	$1,018,359,149	$1,019,877,764	$37,398,352	$1,057,276,117	$1,029,226,891	$50,446,545	$1,079,673,437
2	Less: Allowances	$743,265,348	$745,519,202	$9,153,034	$754,672,236	$756,087,352	$27,783,423	$783,870,775	$763,176,134	$37,476,990	$800,653,124
3	Less: Charity Care	$5,144,570	$5,228,272	$63,353	$5,291,625	$5,228,272	$192,305	$5,420,577	$5,228,272	$259,400	$5,487,672
4	Less: Other Deductions	$9,054,147	$12,436,400	$111,498	$12,547,898	$12,436,400	$338,446	$12,774,846	$12,436,400	$456,529	$12,892,929
	Net Patient Service Revenue	**$243,021,000**	**$242,854,677**	**$2,992,713**	**$245,847,389**	**$246,125,740**	**$9,084,179**	**$255,209,919**	**$248,386,086**	**$12,253,626**	**$260,639,712**
5	Medicare	$94,049,325	$93,959,132	$1,119,364	$95,078,496	$94,250,524	$3,397,755	$97,648,279	$94,408,975	$4,583,224	$98,992,198
6	Medicaid	$49,412,291	$53,348,771	$635,560	$53,984,332	$53,529,715	$1,929,201	$55,458,916	$53,615,899	$2,602,295	$56,218,194
7	CHAMPUS & TriCare	$361,306	$371,375	$4,424	$375,799	$372,204	$13,430	$385,634	$372,816	$18,115	$390,931
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$143,822,921**	**$147,679,278**	**$1,759,349**	**$149,438,627**	**$148,152,443**	**$5,340,386**	**$153,492,829**	**$148,397,690**	**$7,203,633**	**$155,601,323**
9	Commercial Insurers	$100,411,947	$101,432,721	$1,208,399	$102,641,120	$104,211,277	$3,668,015	$107,879,292	$106,209,755	$4,947,777	$111,157,532
10	Uninsured	$128,767	$182,978	$2,180	$185,158	$183,574	$6,617	$190,191	$183,574	$8,925	$192,499
11	Self Pay	$784,862	$800,705	$9,539	$810,244	$805,705	$28,955	$834,660	$808,060	$39,058	$847,118
12	Workers Compensation	$1,419,020	$1,111,804	$13,245	$1,125,049	$1,123,658	$40,205	$1,163,863	$1,134,847	$54,233	$1,189,080
13	Other	($3,546,517)	($8,352,810)	$0	($8,352,810)	($8,350,917)	$0	($8,350,917)	($8,347,840)	$0	($8,347,840)
	Total Non-Government	**$99,198,078**	**$95,175,399**	**$1,233,364**	**$96,408,762**	**$97,973,297**	**$3,743,793**	**$101,717,090**	**$99,988,396**	**$5,049,993**	**$105,038,389**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$243,021,000**	**$242,854,677**	**$2,992,713**	**$245,847,389**	**$246,125,740**	**$9,084,179**	**$255,209,919**	**$248,386,086**	**$12,253,626**	**$260,639,712**
14	Less: Provision for Bad Debts	$4,347,405	$3,468,763	$42,746	**$3,511,509**	$3,516,689	$129,796	**$3,646,485**	$3,543,303	$174,802	**$3,718,105**
	Net Patient Service Revenue less provision for bad debts	**$238,673,596**	**$239,385,914**	**$2,949,967**	**$242,335,881**	**$242,609,051**	**$8,954,382**	**$251,563,434**	**$244,842,783**	**$12,078,824**	**$256,921,607**
15	Other Operating Revenue	$11,694,375	$14,643,067	$0	**$14,643,067**	$14,825,462	$0	**$14,825,462**	$14,878,373	$0	**$14,878,373**
17	Net Assets Released from Restrictions	$5,080,455	$5,251,632	($2,625,816)	**$2,625,816**	$5,251,632	($5,251,632)	**$0**	$5,251,632	($5,251,632)	**$0**
	TOTAL OPERATING REVENUE	**$255,448,426**	**$259,280,613**	**$324,151**	**$259,604,764**	**$262,686,146**	**$3,702,750**	**$266,388,896**	**$264,972,788**	**$6,827,192**	**$271,799,980**
B.	**OPERATING EXPENSES**										
1	Salaries and Wages	$120,430,846	$115,590,029	$889,836	$116,479,865	$117,692,915	$2,701,039	$120,393,954	$119,507,521	$3,643,425	$123,150,946
2	Fringe Benefits	$35,027,007	$33,907,301	$261,026	$34,168,326	$34,900,546	$800,964	$35,701,510	$36,161,608	$1,102,459	$37,264,067
3	Physicians Fees	$14,968,038	$12,697,776	$0	$12,697,776	$12,680,260	$0	$12,680,260	$12,682,807	$0	$12,682,807
4	Supplies and Drugs	$29,295,392	$23,712,061	($890,238)	$22,821,823	$23,917,529	($1,406,932)	$22,510,597	$24,142,219	($1,024,865)	$23,117,354
5	Depreciation and Amortization	$7,063,006	$6,849,701	$285,714	$7,135,415	$6,838,400	$857,143	$7,695,543	$6,830,365	$1,428,571	$8,258,936
6	Provision for Bad Debts-Other[b]	$15,000	$15,000	$0	$15,000	$15,000	$0	$15,000	$15,000	$0	$15,000
7	Interest Expense	$1,172,296	$1,346,266	($625,122)	$721,144	$1,346,016	($1,277,229)	$68,787	$1,346,016	($1,309,637)	$36,379
8	Malpractice Insurance Cost	$8,268,731	$6,901,688	$0	$6,901,688	$6,928,910	$0	$6,928,910	$6,931,831	$0	$6,931,831
9	Lease Expense	$4,045,091	$3,612,010	$0	$3,612,010	$3,623,435	$0	$3,623,435	$3,635,055	$0	$3,635,055
10	Other Operating Expenses	$53,166,763	$57,710,072	($1,345,271)	$56,364,801	$57,496,322	($2,012,615)	$55,483,707	$57,779,059	($1,319,221)	$56,459,838
	TOTAL OPERATING EXPENSES	**$273,452,169**	**$262,341,904**	**($1,424,055)**	**$260,917,849**	**$265,439,334**	**($337,630)**	**$265,101,703**	**$269,031,481**	**$2,520,732**	**$271,552,212**
	Provision for Income Taxes[c]	$141,985	$136,181	$785,217	**$921,398**	$136,181	$2,172,366	**$2,308,546**	$136,181	$2,050,340	**$2,186,521**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**($9,768,441)**	**$5,134,676**	**$1,408,798**	**$6,543,474**	**$5,431,229**	**$3,620,294**	**$9,051,523**	**$4,117,688**	**$4,425,395**	**$8,543,083**
	INCOME / (LOSS) FROM OPERATIONS	**($18,145,727)**	**($3,197,472)**	**$962,989**	**($2,234,483)**	**($2,889,369)**	**$1,868,015**	**($1,021,354)**	**($4,194,874)**	**$2,256,121**	**($1,938,753)**
	NON-OPERATING INCOME / REVENUE	$2,425,698	$3,442,234	$0	**$3,442,234**	$3,467,981	$0	**$3,467,981**	$3,494,886	$0	**$3,494,886**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Greater Waterbury Health Network

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

			(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:		FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
			Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description		W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES		**($15,720,030)**	**$244,762**	**$962,989**	**$1,207,751**	**$578,612**	**$1,868,015**	**$2,446,627**	**($699,988)**	**$2,256,121**	**$1,556,133**
C.	**Retained Earnings / Net Assets, beginning of year**		**$45,505,137**	**$29,061,392**	**$0**	**$29,061,392**	**$29,306,154**	**$0**	**$29,306,154**	**$29,884,766**	**$0**	**$29,884,766**
	Retained Earnings / Net Assets, end of year		**$29,061,392**	**$29,306,154**	**$962,989**	**$30,269,143**	**$29,884,766**	**$1,868,015**	**$31,752,781**	**$29,184,779**	**$2,256,121**	**$31,440,900**
	Principal Payments		$44,701	$29,709	($29,709)	**$0**	$14,001	($14,001)	**$0**	$6,571	($6,571)	**$0**
D.	**PROFITABILITY SUMMARY**											
1	Hospital Operating Margin		**-7.0%**	**-1.2%**	**297.1%**	**-0.8%**	**-1.1%**	**50.4%**	**-0.4%**	**-1.6%**	**33.0%**	**-0.7%**
2	Hospital Non Operating Margin		**0.9%**	**1.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**1.3%**
3	Hospital Total Margin		**-6.1%**	**0.1%**	**297.1%**	**0.5%**	**0.2%**	**50.4%**	**0.9%**	**-0.3%**	**33.0%**	**0.6%**
E.	**FTEs**		**1,417**	**1,484**	11	**1,495**	**1,486**	35	**1,521**	**1,489**	47	**1,536**
F.	**VOLUME STATISTICS**[d]											
1	Inpatient Discharges		11,699	11,344	113	**11,457**	11,344	340	**11,684**	11,344	908	**12,252**
2	Outpatient Visits		188,806	192,582	2,042	**194,624**	192,582	6,466	**199,048**	192,582	9,075	**201,657**
	TOTAL VOLUME		**200,505**	**203,926**	**2,155**	**206,081**	**203,926**	**6,806**	**210,732**	**203,926**	**9,983**	**213,909**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Assumed no increases in volume. Only increase was managed care

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Waterbury Hospital

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Financial Worksheet (C):

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14 Actual	FY 15 Projected	FY 15 Projected	FY 15 Projected	FY 16 Projected	FY 16 Projected	FY 16 Projected	FY 17 Projected	FY 17 Projected	FY 17 Projected	FY 18 Projected	FY 18 Projected	FY 18 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$905,475,426	915,214,960		$915,214,960	$921,598,035		$921,598,035	$934,060,739		$934,060,739	$942,681,350		$942,681,350
2	Less: Allowances	$679,028,148	698,950,496		$698,950,496	$702,469,850		$702,469,850	$712,240,611		$712,240,611	$718,999,172		$718,999,172
3	Less: Charity Care	$5,839,904	5,156,745		$5,156,745	$5,243,272		$5,243,272	$5,243,272		$5,243,272	$5,243,272		$5,243,272
4	Less: Other Deductions	$8,287,736	9,039,311		$9,039,311	$12,421,400		$12,421,400	$12,421,400		$12,421,400	$12,421,400		$12,421,400
	Net Patient Service Revenue	**$212,319,638**	**$202,068,409**	**$0**	**$202,068,409**	**$201,463,513**	**$0**	**$201,463,513**	**$204,155,456**	**$0**	**$204,155,456**	**$206,017,506**	**$0**	**$206,017,506**
5	Medicare	$88,141,859	$77,846,951		$77,846,951	$77,683,507		$77,683,507	$77,683,507		$77,683,507	$77,683,507		$77,683,507
6	Medicaid	$31,612,939	$41,641,364		$41,641,364	$45,383,059		$45,383,059	$45,383,059		$45,383,059	$45,383,059		$45,383,059
7	CHAMPUS & TriCare	$278,693	$257,504		$257,504	$264,002		$264,002	$264,002		$264,002	$264,002		$264,002
8	Other				$0			$0			$0			$0
	Total Government	**$120,033,491**	**$119,745,818**	**$0**	**$119,745,818**	**$123,330,568**	**$0**	**$123,330,568**	**$123,330,568**	**$0**	**$123,330,568**	**$123,330,568**	**$0**	**$123,330,568**
9	Commercial Insurers	$94,143,393	$86,925,320		$86,925,320	$87,669,528		$87,669,528	$90,361,471		$90,361,471	$92,223,521		$92,223,521
10	Uninsured		$0		$0			$0			$0			$0
11	Self Pay		$0		$0			$0			$0			$0
12	Workers Compensation		$0		$0			$0			$0			$0
13	Other	($1,857,246)	($4,602,729)		($4,602,729)	($9,536,583)		($9,536,583)	($9,536,583)		($9,536,583)	($9,536,583)		($9,536,583)
	Total Non-Government	**$92,286,147**	**$82,322,591**	**$0**	**$82,322,591**	**$78,132,945**	**$0**	**$78,132,945**	**$80,824,888**	**$0**	**$80,824,888**	**$82,686,938**	**$0**	**$82,686,938**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$212,319,638**	**$202,068,409**	**$0**	**$202,068,409**	**$201,463,513**	**$0**	**$201,463,513**	**$204,155,456**	**$0**	**$204,155,456**	**$206,017,506**	**$0**	**$206,017,506**
14	Less: Provision for Bad Debts	$3,692,986	3,602,119		**$3,602,119**	$2,696,864		**$2,696,864**	$2,732,899		**$2,732,899**	$2,757,825		**$2,757,825**
	Net Patient Service Revenue less provision for bad debts	**$208,626,652**	**$198,466,291**	**$0**	**$198,466,291**	**$198,766,649**	**$0**	**$198,766,649**	**$201,422,556**	**$0**	**$201,422,556**	**$203,259,680**	**$0**	**$203,259,680**
15	Other Operating Revenue	$2,671,751	1,164,098		**$1,164,098**	$2,364,706		**$2,364,706**	$2,364,706		**$2,364,706**	$2,364,706		**$2,364,706**
17	Net Assets Released from Restrictions	$5,542,491	5,080,455		**$5,080,455**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**
	TOTAL OPERATING REVENUE	**$216,840,894**	**$204,710,844**	**$0**	**$204,710,844**	**$206,382,987**	**$0**	**$206,382,987**	**$209,038,894**	**$0**	**$209,038,894**	**$210,876,018**	**$0**	**$210,876,018**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$83,908,937	$82,721,899		$82,721,899	$77,111,340		$77,111,340	$78,653,567		$78,653,567	$80,226,638		$80,226,638
2	Fringe Benefits	$23,614,272	$28,882,017		$28,882,017	$27,269,762		$27,269,762	$28,417,803		$28,417,803	$29,645,411		$29,645,411
3	Physicians Fees	$17,306,125	$11,926,799		$11,926,799	$11,229,459		$11,229,459	$11,229,459		$11,229,459	$11,229,459		$11,229,459
4	Supplies and Drugs	$29,780,875	$27,722,303		$27,722,303	$21,913,022		$21,913,022	$22,125,763		$22,125,763	$22,344,887		$22,344,887
5	Depreciation and Amortization	$7,077,295	$6,340,513		$6,340,513	$6,200,315		$6,200,315	$6,200,315		$6,200,315	$6,200,315		$6,200,315
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0			$0			$0
7	Interest Expense	$1,196,363	$1,169,431		$1,169,431	$1,345,947		$1,345,947	$1,345,947		$1,345,947	$1,345,947		$1,345,947
8	Malpractice Insurance Cost	$6,226,587	$6,543,668		$6,543,668	$5,392,785		$5,392,785	$5,392,785		$5,392,785	$5,392,785		$5,392,785
9	Lease Expense	$2,599,451	$2,852,443		$2,852,443	$2,401,696		$2,401,696	$2,401,696		$2,401,696	$2,401,696		$2,401,696
10	Other Operating Expenses	$56,039,173	$57,223,873		$57,223,873	$58,849,639		$58,849,639	$58,393,012		$58,393,012	$58,506,655		$58,506,655
	TOTAL OPERATING EXPENSES	**$227,749,078**	**$225,382,944**	**$0**	**$225,382,944**	**$211,713,965**	**$0**	**$211,713,965**	**$214,160,347**	**$0**	**$214,160,347**	**$217,293,793**	**$0**	**$217,293,793**
	Provision for Income Taxes[c]				**$0**			**$0**			**$0**			**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**($2,634,526)**	**($13,162,156)**	**$0**	**($13,162,156)**	**$2,215,284**	**$0**	**$2,215,284**	**$2,424,809**	**$0**	**$2,424,809**	**$1,128,487**	**$0**	**$1,128,487**
	INCOME / (LOSS) FROM OPERATIONS	**($10,908,184)**	**($20,672,100)**	**$0**	**($20,672,100)**	**($5,330,978)**	**$0**	**($5,330,978)**	**($5,121,453)**	**$0**	**($5,121,453)**	**($6,417,775)**	**$0**	**($6,417,775)**
	NON-OPERATING INCOME / REVENUE	$3,136,173	$2,503,676		**$2,503,676**	$2,658,589		**$2,658,589**	$2,658,589		**$2,658,589**	$2,658,589		**$2,658,589**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**($7,772,011)**	**($18,168,424)**	**$0**	**($18,168,424)**	**($2,672,389)**	**$0**	**($2,672,389)**	**($2,462,864)**	**$0**	**($2,462,864)**	**($3,759,186)**	**$0**	**($3,759,186)**
C	**Retained Earnings / Net Assets, beginning of year**	**$18,667,399**	**$11,890,055**		**$11,890,055**	**($4,698,443)**		**($4,698,443)**	**($7,370,832)**		**($7,370,832)**	**($9,833,696)**		**($9,833,696)**

Assumed no increases in volume. Only increase was managed care

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Waterbury Hospital

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	Retained Earnings / Net Assets, end of year	$11,890,055	($4,698,443)		($4,698,443)	($7,370,832)		($7,370,832)	($9,833,696)		($9,833,696)	($13,592,881)		($13,592,881)
	Principal Payments				$0			$0			$0			$0
D.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	-5.0%	-10.0%	0.0%	-10.0%	-2.6%	0.0%	-2.6%	-2.4%	0.0%	-2.4%	-3.0%	0.0%	-3.0%
2	Hospital Non Operating Margin	1.4%	1.2%	0.0%	1.2%	1.3%	0.0%	1.3%	1.3%	0.0%	1.3%	1.2%	0.0%	1.2%
3	Hospital Total Margin	-3.5%	-8.8%	0.0%	-8.8%	-1.3%	0.0%	-1.3%	-1.2%	0.0%	-1.2%	-1.8%	0.0%	-1.8%
E.	FTEs	1,152	1,028		1,028	1,091		1,091	1,091		1,091	1,091		1,091
F.	VOLUME STATISTICS[d]													
1	Inpatient Discharges	11,693	11,699		11,699	11,344		11,344	11,344		11,344	11,344		11,344
2	Outpatient Visits	199,362	188,806		188,806	192,582		192,582	192,582		192,582	192,582		192,582
	TOTAL VOLUME	211,055	200,505	0	200,505	203,926	0	203,926	203,926	0	203,926	203,926	0	203,926

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT Q38-1

ASSUMPTIONS UTILIZED IN DEVELOPING FINANCIAL WORKSHEET (C)

Assumptions Utilized in Developing Financial Worksheet (C):

Waterbury Hospital:

FY15: October through August actual results annualized.

FY16:

Revenue and Volume annualized 5 months of actual results (February through June). Included additional revenue for anticipated increase in outpatient visits and known revenue increases from Medicare and Commercial Insurances.

Expenses annualized 7 months of actual results (October through April). Included any projected increases.

Both revenue and expenses reflect expected changes due to the impact of the recent State Supplemental Pool payment cuts.

FY17 and FY18:

FTEs and Volume was kept the same as the budget. No increases.

Only revenue increase was for known Commercial Insurance revenue increases.

Expenses remained the same as budget with a few increasing by 2-3 each year.

Alliance Medical Group:

For FY15 revenue, we took an average of the previous 11 months for individual government and non-government revenue. For everything else that fiscal year, we used the 11 month year to date plus the month of August 2015 again.

FY 16 is based on potential visit volumes for the upcoming year, with expected changes due to the impact of the recent State Supplemental Pool payments.

FY17 and FY18 is based on the expected increase of 1 and 2 year to year due to the primary care recruitment which will include opening offices in new markets. Expenses stayed the same as FY 16.

For the new fiscal years, there has been extensive evaluation of the expenses associated with the hospital and all affiliates. The hospital engaged the Camden Group to look at opportunities to remove expenses from the organization and we have begun or about to begin implementing many of these based on the data analyzed. Our goal moving forward and starting in FY 2016 is to increase our revenue capability but also make significant changes that will allow us to decrease our expenses where appropriate.

Prospect Incremental Assumptions

FY16 Incremental:

Assumed Conversion date of April 1st, 2016

Revenue and Volume Increases of 1□

Expenses: Loss of 340B Pharmacy Pricing, efficiency on GPO Purchasing Contracts, Volume increases.

Interest Expense related to assumed Capital Leases.

Does not include associated Property and Sales Tax Increases.

FY17 & 18 Incremental:

Revenue and Volume Increases of 3□ and 4□ respectively.

Expenses: Loss of 340B Pharmacy Pricing, efficiency on GPO Purchasing Contracts, Volume increases.

Interest Expense related to assumed Capital Leases.

Does not include associated Property and Sales Tax Increases.

EXHIBIT Q42-1

STAFFING ATTACHMENT I (2015)

Staffing Attachment I

Question No. 42 - Part a

Current Staffing Levels				Current Staffing Levels			Current Staffing Levels	
Average Nursing staff to patient rato - Item no. i				Average RN to Patient Ratio - Item no. ii			Avg Nursing Hrs/Pt Day - Item no. iii	
Department or Unit Name	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**	**NHpPD**	**Comments**
CVU RN	1:2/3	1:2/3	1:2/3	1:2/3	1:2/3	1:2/3	7	
CVU PCA	1:8	1:8 x 2 hrs	0					
ICU RN	1:2	1:2	1:2	1:2	1:2	1:2	12	
ICU PCA	1:20	1:20	0					
Family Birthing Center (Post Partum-cuplets) RN	1:3-5	n/a 12hour shifts	1:4-5	1:3-5	n/a 12hour shifts	1:4-5		
FBC Surgical Techs	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven		
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven		
Labor and Delivery RN	1:1-2	12 hour shifts	1:1-2	1:1-2	12 hour shifts	1:1-2		nurses work 12 hour shifts
Special Care Nursery RN	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3		
Well Baby Nursery RN	n/a	n/a	1:6	n/a	n/a	1:6		only open on night shift
Telemetry RN	1:4-5	1:4-5	1:5-6	1:4-5	1:4-5	1:5-6	9.0	RN and PCA +MW
Telemetry PCA	1:8-9+Monitor watcher	1:10+MW	1:10+MW					
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7	1:5-6	1:5-6	1:6-7	7.3	RN and PCA
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12					
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7	1:5-6	1:5-6	1:6-7	8.1	Ortho/Neuro unit
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+ PT aid	1:10-12	1:10-12					
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12	1:6-8	1:6-8	1:8-12	7.4	
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12					
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p		Admit RN 11a-11p	Admit RN 11a-11p			
Pomeroy 8 PCA	1*	1*	1*					
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4	1:3-4	1:3-4	1:3-4	6	
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:6-7	1:5-6	1:5-6	1:6-7	7.5	RN and PCA
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12					
Emergency Department RN	C ore: 7/11	11	7/6	C ore: 7/11	11	7/6	n/a	
Emergency Department PCA	Core: 3/4	5	3/2					

FootNote - (1) Nursing staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.
Also included are Surgical and Psychiatric technicians as they provide direct patient care.

EXHIBIT Q42-2

STAFFING ATTACHEMENT II (PROJECTED)

Staffing Attachment I I

Projected Staffing Level FY 2016- Year 1

Question No. 42 - Part b

Projected Staffing Levels			
Average Nurse (1) to Patient Ratio - Item no. i			
Department or Unit Name	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**
CVU RN	1:2/3	1:2/3	1:2/3
CVU PCA	1:8	1:8 x 2 hrs	0
ICU RN	1:2	1:2	1:2
ICU PCA	1:20	1:20	0
Family Birthing Center (Post Partum-cuplets) RN	1:3-5	12 hour shifts	1:4-5
FBC Surgical Techs	1 not ratio driven	1 not ratio driven	1 not ratio driven
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven
Labor and Delivery RN	1: 1-2	12 hour shifts	1:1-2
Special Care Nursery RN	1:2-3	1:2-3	1:2-3
Well Baby Nursery RN	n/a	n/a	1:6
Telemetry RN	1:4-5	1:4-5	1:5-6
Telemetry PCA	1:8-9+monitor watcher	1:10+MW	1:10+MW
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+PT aid	1:10-12	1:10-12
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p	
Pomeroy 8 PCA	1*	1*	1*
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:6:7
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12
Emergency Department RN	C ore: 7/11	11	7/6
Emergency Department PCA	Core: 3/4	5	3/2

Projected Staffing Levels		
Average RN to Patient Ratio - Item no. ii		
Shift #1 AM	**Shift #2 PM**	**Shift #3 overnight**
1:2/3	1:2/3	1:2/3
1:2	1:2	1:2
1:3-4	12 hour shifts	1:4-5
1 not ratio driven	1 not ratio driven	1 not ratio driven
1: 1-2	12 hour shifts	1:1-2
1:2-3	1:2-3	1:2-3
n/a	n/a	1:6
1:4-5	1:4-5	1:5-6
1:5-6	1:5-6	1:6-7
1:5-6	1:5-6	1:6-7
1:6-8	1:6-8	1:8-12
Admit RN 11a-11p	Admit RN 11a-11p	
1:3-4	1:3-4	1:3-4
1:5-6	1:5-6	1:6-7
C ore: 7/11	11	7/6

FootNote - (1) Nursing staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.

Staffing Attachment I I

Projected Staffing Level FY 2017 - Year 2

Question No. 1 - Part b

Projected Staffing Levels
Average Nurse (1) to Patient Ratio - Item no. i

Department or Unit Name	Shift #1 AM	Shift #2 PM	Shift #3 overnight
CVU RN	1:2/3	1:2/3	1:2/3
CVU PCA	1:8	1:8 x 2 hrs	0
ICU RN	1:2	1:2	1:2
ICU PCA	1:20	1:20	0
Family Birthing Center (Post Partum-cuplets) RN	1:3-4	12 hour shifts	1:4-5
FBC Surgical Techs			
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven
Labor and Delivery RN	1: 1-2	12 hour shifts	1:1-2
Special Care Nursery RN	1:2-3	1:2-3	1:2-3
Well Baby Nursery RN	n/a	n/a	1:6
Telemetry RN			
Telemetry PCA	1:8-9 + MW	1:10+MW	1:10+MW
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+PT aid	1:10-12	1:10-12
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p	
Pomeroy 8 PCA	1*	1*	1*
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:6-7
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12
Emergency Department RN	C ore: 7/11	11	7/6
Emergency Department PCA	Core: 3/4	5	3/2

Projected Staffing Levels
Average RN to Patient Ratio - Item no. ii

Shift #1 AM	Shift #2 PM	Shift #3 overnight
1:2/3	1:2/3	1:2/3
1:2	1:2	1:2
1 not ratio driven	1 not ratio driven	1 not ratio driven
1: 1-2	12 hour shifts	1:1-2
1:2-3	1:2-3	1:2-3
n/a	n/a	1:6
1:5-6	1:5-6	1:5-6
1:6-8	1:6-8	1:8-12
Admit RN 11a-11p	Admit RN 11a-11p	
1:3-4	1:3-4	1:3-4
1:5-6	1:5-6	1:6-7
C ore: 7/11	11	7/6

Staffing Attachment I I

Projected Staffing Level FY 2018 - Year 3

Question No. 1 - Part b

Projected Staffing Levels			
Average Nurse (1) to Patient Ratio - Item no. i			
Department or Unit Name	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**
CVU RN	1:2/3	1:2/3	1:2/3
CVU PCA	1:8	1:8 x 2 hrs	0
ICU RN	1:2	1:2	1:2
ICU PCA	1:20	1:20	0
Family Birthing Center (Post Partum-cuplets) RN			
FBC Surgical Techs			
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven
Labor and Delivery RN	1: 1-2	12 hour shifts	1:1-2
Special Care Nursery RN	1:2-3	1:2-3	1:2-3
Well Baby Nursery RN	n/a	n/a	1:6
Telemetry RN	1:4-5	1:4-5	1:5-6
Telemetry PCA	1:8-9+MW	1:10+MW	1:10+MW
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+PT aid	1:10-12	1:10-12
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p	
Pomeroy 8 PCA	1*	1*	1*
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:5-6
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12
Emergency Department RN	C ore: 7/11	11	7/6
Emergency Department PCA	Core: 3/4	5	3/2

Projected Staffing Levels		
Average RN to Patient Ratio - Item no. ii		
Shift #1 AM	**Shift #2 PM**	**Shift #3 overnight**
1:2/3	1:2/3	1:2/3
1:2	1:2	1:2
1: 1-2	12 hour shifts	1:1-2
1:2-3	1:2-3	1:2-3
n/a	n/a	1:6
1:4-5	1:4-5	1:5-6
1:5-6	1:5-6	1:6-7
1:5-6	1:5-6	1:6-7
1:6-8	1:6-8	1:8-12
Admit RN 11a-11p	Admit RN 11a-11p	
1:3-4	1:3-4	1:3-4
1:5-6	1:5-6	1:6-7
C ore: 7/11	11	7/6

EXHIBIT Q44-1

ANCILLARY CAREGIVER STAFFING ATTACHMENT (2015 AND PROJECTED)

FY-15 Staffing Hours			Projected Staffing Hours		
			FY-16	FY-17	FY-18
Item a.		Item b.	Item c.		
Department	Ancillary Care Provider	Avg. # hours /week care provided	FY 1	FY 2	FY 3
Cardiology	**Echosonographer**	72	104	104	104
Cardiology	**Stress Testing -Technician**	40	40	40	40
Cardiology	**Stress Testing - APRN**	30	70	70	70
Cardiology	**Cardiac Rehab- RN and Techs**	124	124	124	124
Pulmonary Function Lab	**Pulmonary Function Lab**	16	16	16	16
Radiology	**Radiology Technicians**	557	622	622	622
Radiology	**Ultrasonographers**	173	237	237	237
Radiology	**CT Technicians**	332	341	341	341
Radiology	**Interventional Radiology RN**	133	113	113	113
Radiology	**Interventional Radiology Technician**	130	130	130	130
Radiology	**Nuclear Medicine Technician**	87	87	87	87
Hemodyalisis Contracted Service	**RNs**	65	65	65	65
Emergency Department	**Physician Assistants**	210	210	210	210
Respiratory Therapy	**Respiratory Therapists**	644	644	644	644
Laboratory Services	**Laboratory Personnel**	1,642	1,642	1,642	1,642
Laboratory Services	**Phlebotomists**	575	575	575	575
Pharmacy	**Pharmacists**	590	590	590	590
Rehabilitation	**Physical Therapists**	211	211	211	211
Rehabilitation	**Physical Therypy Assistants**	90	90	90	90
Rehabilitation	**Occupational Therapists**	12	12	12	12
Rehabilitation	**Occupational Therapy Assistant**	26	26	26	26
Rehabilitation	**Speech Therapists**	39	39	39	39
Sleep Laboratory	**Sleep Lab Personnel**	240	240	240	240
Cardiac Diagnostics	**APRN**	40	40	40	40
Cardiac Diagnostics	**Anticoagulation Specialist**	64	64	64	64
Cardiac Diagnostics	**Anticoagulation Clinician**	24	24	24	24
Cardiac Diagnostics	**Nuclear Medicine Technician**	70	70	70	70
Cardiac Diagnostics	**Echosonographer**	80	80	80	80
Cardiac Diagnostics	**Stress Testing RNs**	80	80	80	80
Cardiac Diagnostics	**Medical Assistants**	128	128	128	128
EEG	**EEG Technologists**	70	70	70	70
Hospitalists Program	**Physician**	476	588	588	588
Hospitalists Program	**Physician Assistants**	112	120	120	120
Orthopeadic Program	**Physician Assistants**	280	280	280	280
Surgical Program	**Physician Assistants**	N/A	-	-	-
Gasteroenterology	**RNs**	184	184	184	184
Gasteroenterology	**GI Techs**	72	72	72	72
Outpatient Medical Therapy	**RNs**	160	160	160	160
Catheterization Lab	**Cath Lab RNs**	160	160	160	160
Catheterization Lab	**Cath Lab Techs**	160	160	160	160
Operating Room	**RNs**	600	600	600	600
Operating Room	**Surgical Techs**	420	420	420	420
Post Anesthesia Care Unit	**RNs**	240	240	240	240
One Day Surgery	**RNs**	470	470	470	470
One Day Surgery	**PCAs**	178	178	178	178
Food and Nutrition	**Clinical Dietician**	104	104	104	104

FootNote - (1) Nursing staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.

EXHIBIT Q47-1

PMH STATEMENTS OF DEFICIENCY AND PLANS OF CORRECTIONS

PMH Response to Question 47
Summary of Statements of Deficiency/ Plans of Correction
PMH-Owned Rhode Island Hospital Facilities

ST. JOSEPH HEALTH SERVICES OF RHODE ISLAND – COMPLAINT VALIDATION SURVEY

On June 23, 2014, a complaint validation survey at St. Joseph Health Services of Rhode Island was completed by the Rhode Island Department of Health (the "DOH"). Several deficiencies were noted involving the failure to implement hospital policies for "Medical Marijuana;" "Documented Informed Consent for AIDS/HIV and Confidentiality;" "Patient Search Policy;" "Constant Observation;" "Universal Protocol Policy;" "Annual Performance Competency Review Process;" and failure to report reportable incidents, in writing, to the DOH within 72 hours of incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

ST. JOSEPH'S HEALTH SERVICES OF RHODE ISLAND – COMPLAINT VALIDATION SURVEY

On March 6, 2013, a complaint validation survey was completed by the DOH. Several deficiencies were noted involving the failure to implement hospital policies for "Constant Observation;" "Fall Precaution Policy;" failure to provide care, in accordance with community standard, for bowel care; failure to ensure less restrictive interventions and/or alternatives had been employed and ineffective prior to chemically restraining a patient; and failure to report reportable incidents, in writing, to the DOH within 72 hours of incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

ROGER WILLIAMS MEDICAL CENTER – COMPLAINT VALIDATION SURVEY

On August 20, 2013, a complaint validation survey was completed by the DOH. Several deficiencies were noted to include failure to report reportable incidents, in writing, to the DOH within 72 hours of incident; failure to perform peer review on a reportable incident; and failure to submit a follow-up report to the DOH following a reported incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

St. Joseph Health Services of Rhode Island

200 HIGH SERVICE AVENUE
NORTH PROVIDENCE, RI 02904
(401) 456-3000

WWW.SAINTJOSEPHRI.COM

August 29, 2014

Raymond Rusin, Chief
RI Department of Health,
Division of facilities Regulation
3 Capitol Hill
Providence, RI 02908
In Hand

Re: HOS00110, survey completed 6/23/2014

Dear Mr. Rusin:

Enclosed please find Prospect CharterCARE SJHSRI's Plan of Correction for citations received on August 15, 2014, in the Statement of Deficiencies from the Rhode Island Department of Health, for a visit May 22, 2014 through June 23, 2014.

Sincerely,

Thomas Hughes, FACHE
President
Prospect CharterCARE SJHSRI
200 High Service Ave
North Providence, RI 02904
Attachment

cc Catherine Lynn, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING: _____ B. WING _____	C 6/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

(X) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC INDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 0	INITIAL COMMENTS A State complaint investigation survey, a follow-up (*EJ0011, 6/20/14) to previous State complaint investigation survey, and an 'Other' State licensure survey (DDWN11, 6/20/14) were conducted at this facility. Prior deficiencies are recited, and deficiencies relative to the State complaint investigation survey and the 'Other' State licensure survey are also cited.	Z0		
Z 160	ORGANIZATION & MANAGEMENT 12.2 Organization 12.2 Each hospital department and service shall maintain: a) clearly written definitions of its organization, authority, responsibility and relationships; b) written patient care policies and procedures; and c) written provision for systematic evaluation of programs and services. This Requirement is not met as evidenced by: Based on record review, staff interview, and review of hospital policies, it has been determined that the hospital failed to implement the following policies: 1. "Medical Marijuana", for 1 of 1 relevant sample patients, ID #4; 2. "Documented Informed Consent For AIDS/HIV and Confidentiality", for 5 of 5 relevant sample patients, ID#'s 6, 39, 40, 41 and 42; 3. "Patient Search Policy", for 1 of 1 relevant sample patients, ID #18; 4. "Constant Observation", for 3 of 4 relevant sample patients, ID #'s 2, 27, and 34; 5. "Universal Protocol Policy", for 1 of 6 relevant	Z 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING:_____ B. WING_____	C 6/23/2014

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Z 160	Continue From page 1 sample patients, ID # 26; 6. "Annual Performance Competency Review Process", for 6 of 12 relevant sample employees, ID's A, B, C, D, E and F. Findings are as follows: I.The hospital policy, "Medical Marijuana", dated 10/2012, under "Policy Statement" states, under item b: "If the patient is determined to be a licensed card holder, the material in question will be sent home with the patient or the patient's family. In the event that no family members are available to receive the material, it will be disposed of and destroyed...The pharmacist will contact the patient's prescriber to recommend Marinol (dronabinol) as an oral, FDA (Food and Drug Administration) approved alternative medication to use while the patient is admitted." Review of the clinical record for patient ID #4 reveals that the patient was admitted to the hospital on 3/14/13 for a psychiatric evaluation. The patient presented with a Medical Marijuana Card, and a small amount of marijuana. The patient told staff that there was no significant other to remove the marijuana from the facility, therefore the marijuana was disposed of in the presence of the patient and pharmacy staff in accordance with hospital policy. The record lacked evidence that the patient's physician was contacted by a hospital pharmacist to recommend Marinol during the patient's admission in accordance with the hospital policy.	Z 160	**I. Hospital Policy: Medical Marijuana (#04-953-281)** a. Members of Pharmacy staff will complete and read & sign the above policy and related departmental specific notes of process. **MOS: 100% compliance.** Signature pages will be submitted to Risk Mgt. b. RNs (hospital) will complete read & sign of above policy and departmental specific notes of process. **MOS: 100% compliance.** Read and sign recording will be kept electronically by Nsg Ed. A report will be generated & submitted to Risk Mgt (staff who performed the read & sign.) c. Security Guards will complete a read & sign of above policy and departmental specific notes of process. **MOS: 100% compliance.** Signature pages will be submitted to Risk Mgt. d. **Audit:** All charts of patients admitted with Medical Marijuana will be audited for 6 months to determine compliance with hospital policy and appropriate documentation of intervention & notification to Dir/Mgrs Pharmacy. If goal achieved, a determination will be made as to need for further audits. **MOS: 100% compliance.**	**Pt Safety/ Ethics & P & T Committees** 9/30/2014 10/15/2014 10/15/2014 11/1/2014 – 5/1/2015

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING:_____ B. WING_____	C 6/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

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Z 160	Continued From page 2 During an interview on 5/27/14 at approximately 2 PM with the Lead Operational Pharmacist, who was present when the marijuana was destroyed, it was revealed that contact with the patient's physician regarding prescribing Marinol did not occur. II. The hospital policy, "Documented Informed Consent for AIDS/HIV and Confidentiality", dated 3/2011, under "Policy", item A states: "AIDS tests will only be done with the documented informed consent of the patient..." A review of the clinical record for patient ID #6 reveals the patient was admitted to the facility on 8/2/13 with a question of stroke. While in the hospital the patient had blood work completed which included testing for HIV (human immunodeficiency virus). The medical record lacked evidence of documentation of an informed consent of the HIV testing in accordance with hospital policy. When interviewed on 6/12/14 at approximately 8:30 AM, the ordering physician revealed, "I may have discussed the HIV testing with the patient, but I did not document it; there is an informed consent policy, I usually write it in the record." Review of 4 additional relevant clinical records for patient ID #s 39, 40, 41 and 42 revealed no evidence that informed consent for HIV testing had been obtained in accordance with hospital policy.	Z 160	**II. Hospital Policy: "Documented Informed Consent for AIDS/HIV & Confidentiality" (#04-711-41 aka IP & IC Manual A-2b)** a. Revise above policy to include required HIV Consent Form to be completed by ordering MD/LIP & signed by MD/LIP & patient. Prepare & attach a new HIV Consent Form to be used (available in Meditech.) Add a verification process for completion of above Consent Form & counseling/education prior to HIV test order to be placed in Meditech & accepted. **MOS: Completion of Policy revisions & prepare Consent Form by 10/1/14.** Once above policy is completed, the HIV (Aids) Tests Umbrella Plan IP & IC Manual A-2f will be revised accordingly. b. Create stop gap in Meditech to prevent HIV testing without compliance with policy requirements. **MOS: Completion in Meditech 10/15/14 to begin 11/15/14.** c. Focused physician and healthcare worker education in high volume areas re: policy revisions & stop gap. Areas include: ED, BH, SJHSRI clinics, & Infectious Disease: • MDs/LIPs & MD (involved in citation) • Nurses & Unit secretaries - Skills Fair • SJHSRI Clinic (RN, LPN, MA, Unit secretaries) – Skills Fair **MOS: 100% completion by high volume**	**Patient Safety Committee** 10/1/2014 10/15/2014 10/15/2014 – 11/15/2014

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING: _____ B. WING _____	C 6/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

(X) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC INDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 160	Continued From page 3 III. The hospital policy, Patient Search Policy", dated 8/2010, under "Procedure", Item II, "Patient Search" states: "A patient search is performed by two people in the following circumstances: any patient who demonstrates symptoms which suggests the use of contraband drugs." "The patient search is performed as follows": Item b. "The patient removes clothes and will be placed in a hospital gown and the staff member searches the clothing item…" Review of the clinical record for patient ID #18 revealed that the patient was brought to the ED (emergency department) by EMS (emergency medical services). The patient had been found in respiratory arrest after injecting heroin. The patient regained consciousness after treatment. The physician's clinical impression was "heroin overdose". While being monitored in the ED, the patient became unresponsive. The patient responded to	Z 160	**MDs/LIPs, MD involved in citations & healthcare workers of above areas.** Sign-in sheets/report will be submitted to Risk Mgt. d. **Audit:** All HIV orders entered into Meditech (answer: yes & no) will be reviewed monthly for 3 months. If healthcare worker has to contact MD/LIP for consent, it will be tracked & MD/LIP will be re-educated. If compliance goal is reached, a random audit will continue as appropriate. **MOS: 100% compliance.** **III. Hospital Policy: "Patient Search" (C- 52)** a. Revise above policy to eliminate "Emergency Department", as searches will be detailed in a newly created Risk Assessment Policy & obtain approval. **MOS: Policy will be revised.** b. Draft policy "Emergency Risk Assessment for Behavioral Health Patients" (Risk Assessment Policy) & attached "Emergency Risk Assessment Guide." Risk Assessment to be completed by MDs &/or ED Clinicians - for all patients presenting with psychiatric concerns, substance abuse issues, detox requests &/or overdoses. To be piloted in ED before final approval. **MOS: Pilot implemented.** c. Risk Assessment created in Meditech for ED Clinicians and ED RNs to access & document on patients that meet the policy requirements. **MOS: Risk Assessment completed in Meditech.** d. Risk Assessment created in the EMR for MDS/LIPs to access & documentation on patients that meet policy requirements. This documentation comes with color coding in Meditech & with visual representation	12/1/2014 – 2/1/2015 **Patient Safety Committee** 9/30/2014 Pilot began 6/1/2014 – 10/1/2014 Clinicians: 8/18/2014 RNs: 10/30/2014 8/31/2014

Facilities Regulation
PROVIDER REPRESENTATIVE'S SIGNATURE Thomas Hughes TITLE President, Prospect CharterCARE SJHSRI (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING:_____ B. WING_____	C 6/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC INDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 160	Continued From page 4 treatment. The physician's note reveals, "Patient states s/he found a bag of drugs on the way to the bathroom and used them in the bathroom. Patient still has pants on so it is possible that something was in a pocket..." When interviewed on 6/17/14 at approximately 11:30 AM, the ED Chief revealed, "I feel the care was not optimal, the patient should have been searched." It was determined that the patient was allowed to keep pants on while wearing a hospital gown, and a search for contrabands had not been performed in accordance with the hospital policy. IV. The hospital policy, "Constant Observation", dated 6/2013, under "Policy" states:	Z 160	outside patient's rooms for staff awareness of risk level. **MOS: Risk Assessment completed in EMR.** e. Emergency Risk Assessment Guide will be posted in LSU & Core of ED – quick reference. f. Education provided on above pilot policy & Emergency Risk Assessment Guide for: • ED Clinicians (also documentation) • ED MDs/LIPs (also documentation) • ED RNs • ED CNAs • Security guards **MOS: 100% compliance.** Signature sheets/reports of attendance of all will be submitted to Risk Mgt. For staff who float to the ED, a just in time read & sign will be used. g. Final revision & approval of Risk Assessment Policy - apply to ED. h. **Audits:** Review of completions of the Risk Assessments performed in the ED: • All Risk Assessments completed by ED Clinicians will be reviewed by Access Manager/Lead Clinician for 6 months. If goal achieved, random audits will be determined. • 30 Risk Assessments completed by MDs/LIPs will be reviewed by ED MDs monthly for 3 months. If goal is achieved, random audits will be determined. **MOS: 100% compliance with new Risk Assessment Policy.** **IV. Hospital Policy "Constant Observation" (N-7)**	9/1/2014 8/13/2014 10/1/2014 9/30/2014 9/30/2014 9/30/2014 11/30/2014 12/1/2014 – 5/1/2015 12/1/2014 – 3/1/2015 **Patient Safety Committee**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING:_____ B. WING_____	C 6/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

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Z 160	Continued From page 5 "It is hospital policy to institute a level of Constant Observation for the patient who manifests one or more of the following criteria": Item #2 "Imminent threat to physical or emotional well-being including but not limited to: Reported suicidal/homicidal ideation's." Under, "Definitions", it states: "Constant observation – process of visually monitoring (observing) a patient at all times, regardless of patient activity; goal is to prevent patient from leaving hospital and from causing injury to self or others; may be used with or without patient being in physical restraints." Under, "Procedure", item 5b it states: "Remain with the patient at all times including bathroom visits (door will be left cracked with consideration for privacy but must be visual) and when patients appear to be sleeping focus on visibility of mouth and hands, maintain no more than arms length distance unless otherwise directed…" 1. Review of clinical record for patient ID #2 revealed that the patient was on 1:1 observation. On 4/9/14 at approximately 7:30 AM, the patient could not be found. A search was conducted and the patient was found unharmed at approximately 8:00 AM, in a lower cabinet in the television room. During an interview on 5/28/14 at approximately 3 PM with the Director of Behavioral Health, it was revealed that the person who was assigned to	Z 160	a. Draft Risk Assessment Policy, as well as Meditech and EMR Risk Assessment documentation. Referred to in III a - e. Risk Assessment to be piloted in ED before final approval. Risk Assessment - addresses complex situations (sexual trauma, psychosis & complex grief.) ED to practice Trauma-Informed Care – allow patients self-determination, if appropriate, ability of patient to contract for safety (CFS) with psychiatrically-trained clinician. Risk Assessment addresses: disrobement, searches, medications, restraints & patient's ability to CFS thus negating need for 1:1 observation. b. Education concerning Risk Assessment Policy & documentation is discussed above in III f. c. Final approval of new Risk Assessment Policy - see III g. above. d. Edit and complete revisions of Constant Observation Policy (N-7) to reflect new Risk Assessment Policy," since Risk Assessment will address clinical needs of patient & determine the patient's immediate needs {medication, restraints, disrobement (forcible or not) after negotiations, as well as need for 1:1 or patient's ability to CFS. If patient is able to CFS in ED, then a 1:1 observation will not be required.} In addition, the Constant Observation 1:1 Report Form attached to policy was revised 6/5/2014 to meet the needs of BH Units to provide an increased level of communication between RN & constant observer to better meet patient's needs. It identifies specific behaviors & effective interventions, enhancing & encouraging	See III above See III above See III above 9/2/2014 - 10/14/2014

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Z 160	Continued From page 6 the constant observation monitoring of the patient went to assist other staff when another patient had fallen. It was at this time that patient ID #2 was left unattended. The hospital investigation determined that based on the review of surveillance video, the patient was in the lower cabinet for approximately 27 minutes. 2. Review of the clinical record for patient ID #27 revealed that the patient presented to the ED after an attempted drug overdose. The patient has a psychiatric history of greater than 20 suicide attempts. The documented patient complaint was "major depression and suicidal ideas". The patient was triaged and placed in Room 7. The plan was for the patient to have a psychiatric evaluation. At approximately 11:55 AM, the patient eloped from the ED. A search by security staff found the patient standing at a bus stop across the street from the hospital. The patient was safely brought back to the hospital ED, and placed in the LSU (low stimulus unit) on 1:1 observation. During an interview on 6/16/14 at approximately 9 AM, the Risk Manager revealed that with hospital investigation the triage nurse had reported that the LSU was full when the patient arrived. It was also reported that the patient should have been on a 1:1 upon arrival to the ED, but there was not enough staff and no bed available in the LSU. When interviewed on 6/18/14 at approximately 1:30 PM, the ED nurse who cared for the patient revealed that the patient stated s/he wanted to	Z 160	therapeutic rapport between constant observer and the patient. This will become part of the policy for all units. e. Due to new ED policy concerning Risk Assessment, described above, the following policies will be revised & approved: • N-7 Constant Observation • N-19 Suicide Precautions • N-21 Elopement. f. Education of policy revisions of N-7, N-19 & N-21 for RNs & CNAs: • Mandatory Skills Fair. **MOS: 100% compliance with attendance with the exception of those who are on LOAs from the organization.** Sign-in sheets or Reports on attendance will be submitted to Risk Mgt. g. Any ED patient requiring a psychiatric evaluation is no longer allowed to use the hallway bathroom with 2 exit doors (in the core) but instead must use the bathroom in LSU. h. **BH Units (including 3 South, Geri Psych Unit):** Education of clinical staff on Constant observation policy and Constant Observation Report Form as follows: • CNAs educated at CNA skills Fair • BH Staff (RNs & CNAs) at Mandatory BH Skills Fair **MOS: 100% compliance with attendance.** Sign-in sheets or Report of attendance will be submitted to Risk Mgt. Any staff that does not attend by said date must complete training through Nsg Ed intranet with competency exam. Sign-in sheets to be submitted to Risk Mgt.	9/2/2014 – 10/14/2014 10/15/14 – 10/31/2014 5/1/2014 6/26/2014 7/2/2014 8/29/2014

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Z 160	Continued From page 7 commit suicide. However, the patient was left in a room without 1:1 supervision, reportedly due to a lack of sufficient staff. 3. Review of the clinical record for patient ID# 34 reveals the patient was brought to the ED via EMS for making suicidal statements to his/her father. The patient has a past suicidal attempt in December of 2013. Review of the triage notes reveals the patient did express feelings of depression and thoughts of harming self. The patient was placed on suicide precautions and 1:1 observation. At approximately 2:15 AM the patient was accompanied to the bathroom by the registered nurse. While in the bathroom, the patient opened the other door to the bathroom and fled the ED. The local police were notified, found the patient, and brought him/her back to the ED. During an interview on 6/18/14 at approximately 10 AM with the Risk Manager, she revealed the patient was placed in the "core" area of the ED on arrival. A hallway bathroom was used that has 2 doors, one of which goes to the waiting area. Surveillance video shows the patient was escorted to the bathroom by the RN. The patient was allowed to close the door completely, putting the patient out of view of the RN and security officer. The patient then fled out of the other door leading to the waiting area. The patient was not in full view of staff in accordance with the hospital policy.	Z 160	i. **BH Units:** Educational program developed for BH Skills Fair will be reviewed during BH orientation for new hires. Also on the intranet. j. **3 South Audit:** Documentations of all patients on 1:1 observation will be reviewed for 3 months for compliance; then documentation of 50% of patients who are on 1:1 observation will be reviewed for compliance and will continue to be audited until goal is reached. **MOS: 100% compliance.** k. Hire consultant & hospital staff (ED & 3 South) to participate in RCA & corrective action plan on constant observation of patients	8/29/2014 8/1/2014 – 11/1/2014 11/1/2014 until compliance is reached. Submit name to DOH – await approval

Facilities Regulation
PROVIDER REPRESENTATIVE'S SIGNATURE Thomas Hughes TITLE President, Prospect CharterCARE SJHSRI (X6) DATE

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Z 160	Continued From page 8 V. The hospital policy, "Universal Protocol Policy", dated 9/2012, under "Marking the Operative Site", states: "All patients having an invasive procedure/surgical procedure that involve laterality...will have their site marked." "The surgeon will mark the site with his initials. The exception to this is Spinal level, which will be completed as follows: Skin marked at the level of the procedure (e.g. cervical, thoracic, lumbar) The skin mark indicates anterior vs. posterior and right vs. left." Under, "Time-out Process," it states: "An incision will not be made until the circulating nurse or procedure assistant and physician/dentist together along with the SRNA/CRNA/Anesthesiologist (student registered nurse anesthetist/certified registered nurse anesthetist) (if appropriate) actively verifies the surgical information. The physician will initiate "time-out" for the verification process. All staff involved in the procedure (Physician, Anesthesia, Circulating Nurse, Scrub Tech) will pause, take a time-out to verify: The correct patient The correct procedure Correct site/side (confirmed with consent by RN/licensed provider) Physician's initials on procedure site/side visible after prepping and draping, can we see the mark?"	Z160	**V. Hospital Policy: "Universal Protocol" (#04-953-130)** a. Education completed re: Universal Protocol and forms used provided to Radiology Staff. **MOS: 100% compliance** Copies of sign in sheet provided to Risk Management. b. Same education provided to 4 Radiologists (who perform IR procedures.) c. Hospital wide Universal Protocol in-service which Includes: PowerPoint presentation, handouts & post test. **MOS: 100% mandatory attendance by Anesthesia & Diagnostic Imaging Depts and 100% completion of post test.** Sign-in sheets & post tests to be submitted to Risk Mgt. Also invited to attend: OR staff, ED, Critical Care, Endoscopy & other areas of the hospital. d. Mandatory Universal Protocol in-service will be provided to new anesthesia group - sub contractor – anticipated start date 12/2014. **MOS: 100% compliance with attendance & completion of post test.** Sign in sheet & post tests submitted to Risk Management. e. Mandatory Universal Protocol in-service to be part of orientation in the following clinical areas: Diagnostic Imaging, OR, & Endoscopy. **MOS: 100% compliance with attendance & completion of post test.**	**Patient Safety Committee** 10/14/2013 10/2013 9/10/2014 Anticipated 12/2014 10/1/2014

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Z 160	Continued From page 9 Review of the clinical record for patient ID# 26 reveals on 5/22/13 the patient underwent a lumbar and sacral dorsal rami block for right lower back pain. The procedure documentation reveals, "Left L5 (lumbar) and sacral L1, L2, L3 and L4 dorsal rami block." The procedure documentation by the physician revealed that at the conclusion of the procedure, it was realized that a left sided injection was performed. This was done despite documentation in the patient's history and physical that his/her pain was principally right sided. Informed consent was for a right sided injection. It was confirmed with the patient that the right side was to be done. Review of the Procedure Assessment/Plan lacks evidence that the site was verified and marked. During an interview on 6/13/14 at approximately 12:15 PM, the Risk Manager revealed in the hospital investigation that it was realized that those involved in the procedure did not actively participate during the time-out. During the time-out, the radiological technician and physician had started the procedure, and the nurse was doing paperwork. There were no site markings in accordance with hospital policy. Additionally, the "Universal Protocol checklist Non-Operating Room" documentation was not used. When interviewed on 6/17/14 at approximately 12:30 PM, the Chief of Anesthesia revealed the site should have been marked per hospital protocol. During the time-out, everyone is to stop what they are doing and listen to the physician at this time; all in the room should participate during	Z160	f. When applicable, mandatory Universal Protocol in-service will be provided to new professional service groups as their contracts commence g. **Audit:** All needle puncture procedures in Special Procedures, Interventional Radiology, Mammography & Ultrasound will be completed monthly for compliance with the policy for 6 months. If goal is achieved random auditing will be determined. **MOS: 100% compliance.**	Anticipated 1/2015 11/1/2014 – 5/1/2015

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Z 160	Continued From page 10 the time out. During an interview on 6/18/14 at approximately 2:20 PM, the Radiological Technician revealed, "when we do a time out or briefing we should all be in the room. I was not in the room when the time-out was done; I was in the control room entering patient information into the computer." The physician and the nurse were in the room and did the time-out without the technician being present. VI. The hospital policy, "Annual Competency Based Evaluation System", dated 7/2010, under "Procedure" item B states: "It is the responsibility of the department manager/supervisor to document performance and assess competency on an ongoing basis on an evaluation and meet with their employees as soon as possible." Also, review of the hospital policy dated 4/2013, entitled "Annual Performance Competency Review Process," under "Policy Statement," states: "A documented annual Performance Review is required of all CharterCARE Health Partner employees in a budgeted position, employees in a per diem position who work 350 or more hours in a year, as well as contracted staff and volunteers..." Review of 6 out of 12 employee files lacked evidence of an annual performance evaluation, (Employee ID's A, B, C, D, E and F).	Z160	**VI. Hospital Policy: "Annual Competency Based Evaluation System" (#HR-600-00021-0)** a. All evaluations for non-union employees - due by October 30th each year. All Evaluations for union employees are completed by employee anniversary date. **MOS: 98% compliance for 2013.** b. Managers have ability to access compliance report in Meditech. In addition, HR Generalists will send out reminders on a bi-weekly basis. **MOS: HR reminders will be sent to Managers biweekly starting 8/29/2014.** c. Revise above policy to include Performance Improvement Process (PIP.) **MOS: Policy revisions completed by 9/1/2014.** d. HR will provide mandatory training sessions for all of leadership on: • 4 step performance review process	**Members of Prospect CharterCARE Sr Leadership/ & BOT** Effective October 2013 Immediately Start 8/29/2014 9/1/2014 9/30/2014

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Z 160	Continued From page 11 ID's A & B lacked an annual performance evaluation for 2012. ID C lacked an annual performance evaluation for 2011 and 2012. ID's D & F lacked an annual performance evaluation for 2012. ID E lacked an annual performance evaluation for 2012 and 2013. When interviewed on 6/4/14 at approximately 2:30 PM, the Vice President of Human Resources revealed that the policy is for annual evaluations, and efforts have been made over the years to enforce this policy.	Z 160	◦ Utilization of Meditech for accessing reports on compliance with performance reviews. **MOS: 100% compliance with attendance.** Sign – in sheets to be submitted to Risk Mgt. e. Corrective actions will be issued to Mgrs/Supervisors/Dirs who are not in 100% compliance after 10/30/2014, as well as hold their merit, if applicable. **MOS: 90% compliance** **Audit:** Compliance reports will be updated monthly. Copy of audit reports will be submitted to Risk Mgt. HR will provide the corrective action template and recommendations to Dir/VP accordingly. PIPs issued will be submitted to Risk Mgt for continued tracking.	12/30/2014
Z940	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on document review and staff interview, it has been determined that the hospital failed to report, in writing to the licensing agency, reportable incidents within 72 hours for 5 of 18 relevant sample patients (ID#'s 26, 29, 30, 36 and 38).	Z940	**Patient Care Services 34.8 Reportable Incidents** a. Identify units involved in citation (late reporting) in RL 6 & to Risk Mgt (pager) (for specific events/harm levels) & reasons. **MOS: Complete identification.** b. Review past DOH reporting audits 8/1/2013 – 7/1/2014 to identify: units involved & common reasons for late reporting. **MOS: Complete list of reasons.** c. Speak with members of Nursing Safety Council about (late reporting) to determine reasons & obtain suggestions for easier frontline reports. Include suggestions in further education & changes.	**Patient Safety Committee** 8/19/2014 9/30/2014 9/30/2014

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Z940	Continued From page 12 Findings are as follows: 1. A reportable incident occurring for patient ID# 26 on 5/22/13 was not reported to the licensing agency until 5/28/13. 2. A reportable incident occurring for patient ID# 29 on 12/30/13 was not reported to the licensing agency until 1/7/14. 3. A reportable incident occurring for patient ID# 30 on 11/7/13 was not reported to the licensing agency until 11/18/13. 4. A reportable incident occurring for patient ID# 36 on 10/31/13 was not reported to the licensing agency until 11/6/13. 5. A reportable incident occurring for patient ID# 38 on 12/8/13 was not reported to the licensing agency until 1/30/14. During an interview on 6/20/14 at approximately 1:30 PM with the Risk Manager, she was unable to provide evidence that the above incidents were reported to the licensing agency within 72 hours as required, and indicated that she frequently gets these reports late from staff.	Z940	d. Hire consultant & participate in RCA & corrective action plan on timely reporting to DOH. e. Educate clinical staff on units identified re: positive, non-punitive aspect of RL 6 & use of RL 6 to promote culture of safety; near miss events - importance of entering near misses, learning tool & way to improve safe patient care; types of events to report & importance of timely reporting. o How to enter an RL 6 report, necessary information needed & how to classify harm. o Types of events to report (specific examples for specialized depts), circumstances Risk Mgt should be paged & include examples of "Near Misses" where incidents have been prevented by RL 6 reporting. **MOS: 90% compliance in attendance.** f. Create mandatory education packet for clinical staff concerning types of events to report in RL 6, timeliness of reporting & severity scores to be completed during orientation along with post-test. Work with Nsg Ed on integration of this mandatory education into clinical orientation & to be tracked with all mandatory orientation requirements. g. Work with Nsg Ed re: training of clinical staff during nsg orientation on how to enter an RL 6 & the plan for implementation. h. Risk Mgt to create list for leaders & clinical staff on when Risk Mgt should be paged (event types & particular severity levels) & provide to Mgrs. **MOS: Complete list.**	Submit name to DOH - await approval 10/30/2014 11/30/2014 12/1/2014 11/30/2014 9/30/2014

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Z940	Continued From page 13	Z940		
			i. In addition to Risk Mgt's usual availability to support leadership with RL 6 technical issues Risk Mgt will schedule quarterly meetings with Mgrs/Directors/various Nursing Practice Councils to support & assist staff with RL 6. **MOS: 100% compliance with scheduling mtgs.**	12/1/2014
			j. Explore with RL Solutions whether Risk Mgt staff can receive automatic notification via email if an RL 6 is entered with severity level of E or greater. If so, change profiles of Risk Mgt staff.	9/30/2014
			k. **Audit:** All reporting to DOH will be reviewed for date & timeliness reported in RL 6; how Risk Mgt was notified, date report sent to DOH & timeliness; if not timely DOH report, why – RM, unit or other issue; & specific reason. Copies of audit findings will be sent to Mgrs/Directors, Practice Council Steering Committee, CNO & President.	9/30/2014 – 3/30/2015
			MOS: All units will be at 100% compliance with on time reporting in RL 6 & to RM.	3/30/2015
			MOS: Risk Mgt will be at 100% compliance with reporting to DOH.	3/30/2015

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St. Joseph Health Services of Rhode Island

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200 HIGH SERVICE AVENUE
NORTH PROVIDENCE, RI 02904
(401) 456-3000

April 22, 2013

Raymond Rusin, Chief
RI Department of Health, Division of Facilities Regulations
Three Capitol Hill
Providence, RI 02908
In Hand with Return Receipt

RE: HOS00110, survey completed 3/6/2013

Dear Mr. Rusin:

Documents:

Enclosed please find St. Joseph Health Services of RI's Plan of Correction for citations received in the Statement of Deficiencies from the Rhode Island Department of Health for a survey beginning on January 22, 2013 that was completed March 6, 2013.

In addition, I would like to acknowledge Madeline Vincent & her staff who will be meeting with Pat Nadle on Thursday, April 25, 2013 to enhance our attached Action Plan.

Sincerely,

Kenneth Belcher
President & CEO
St. Joseph Health Services of RI

Attachment

cc: Madeline Vincent
Michael Conklin
Kim O'Connell, Esquire
Patricia Nadle

Hand deliver to Raymond Rusin, Chief, Action Plan for HOS00110, survey completed 3/6/2013 on Monday, April 22, 2013.

Andrea Powers

NAME

4/22/13

DATE

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Z 0	INITIAL COMMENTS A State complaint investigation survey, an "Other" State survey (ION111, 3/06/13), and a follow-up to a State complaint investigation survey (*J07112, 3/06/13) were conducted at this facility. Prior deficiencies were recited and deficiencies were cited relative to the State complaint investigation and the "Other" State survey.	Z0	**In order to maintain gains for all ongoing monitoring below, adjustments of Action Plans will be made as necessary.**	
Z 160	ORGANIZATION & MANGEMENT 12.2 Organization 12.2 Each hospital department and service shall maintain: a) clearly written definitions of its organization, authority, responsibility and relationships; b)written patient care policies and procedures; and c) written provision for systematic evaluation of programs and services. This Requirement is not met as evidenced by: cBased on record review, staff interview , and review of hospital policies, it was determined that the hospital failed to implement the policy entitled "Constant Observation" for 1 of 3 relevant sample patients (ID #'s 8, 15, 29, 30 and 32). Findings are as follows: 1. A review of the hospital policy entitled "Constant Observation," under "Policy" states: "It is hospital policy to institute a level of Constant Observation for the patient who manifests one or more of the following criteria: Imminent threat to physical or emotional	Z 160	**<u>Elopement of SI Pt on Constant Observation:</u>** 1. ED will utilize a CNA identified from the CNA pool, who will to fill the role of constant observer 24/7, if needed. **MOS: Target 100%** -Confirm availability and utilization of CNA as constant observer from staffing sheets for 1 mth. 2. Review & revise Constant Observation Policy #N-7 in conjunction w/ Suicide Precautions Policy #N-19 & Elopement of Patients Policy # N-21 (along with Security Elopement policy #E-002) to meet best practice guidelines and will include but not be limited to: (define 1 to 1 v. line of site & other types of observation; remove contradictions from policy; add section for non-clinical observer; revise decision algorithm; & develop consistent documentation tool to be utilized by constant observer.) 3. Education of revisions of N-7, N-19, & N-21 for all areas that may have a pt on constant observation: {ED, Housewide	5/31/13 Pt. Safety: 6/13/13 5/31/13 6/30/13

Facilities Regulation

Kenneth Allden President/CEO 4/22/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING: _____ B. WING _____	03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

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Z 160	Continue From page 1 well-being (Suicidal or Violent Behavior Precautions) including but not limited to: Reported suicidal/homicidal ideation's." Under ""Procedure" it states: "At no time should the patient be left alone or unobserved (exception: diagnostic testing)" A review of the clinical record for patient ID #49 revealed that the patient was transported to the hospital via EMS (Emergency Medical Services) for a psychiatric evaluation after a hanging attempt. The patient was evaluated by behavioral health services, and the case was discussed with a hospital psychiatrist. It was determined that the patient would be admitted for suicidal ideation. Physician's orders while in the ED revealed the patient to be placed on "one to one" constant observation. A review of the ED physician's note revealed "Appropriate security watch urgently ordered by me after the patient's arrival in ED; patient is a potential danger to self." Review of the ED documentation revealed that at approximately 9:30 AM the patient eloped from the hospital. The police were notified, and the patient was located and returned to the hospital. During an interview on 2/21/13 at approximately 9:30 AM with the Director or Security; he reported that the SO (Security Officer) assigned to constant observation of the patient was "watching 3 rooms at that time". He further reported that the patient was on constant observation for suicidal and elopement risk, and "should have been 1:1 with the officer". Additionally, the officer should not have been watching other	Z 160	(include per diem & float staff RNs, CNAs & MHWs), & Security.) **MOS: 90 - 100% Compliance**–Read & Sign policies which will be documented in API tracking software. 4. Develop annual mandatory competency for constant observation re: role, intention, requirements & documentation. This competency will be completed by: All ED staff, security, & float staff who work in ED. **MOS: 90-100% Compliance** - Completion of competency. **MOS: 100% Compliance** **Audit 100% charts/ mth for 3 mths** to determine if suicidal/homicidal pts are actually placed on constant observation & documentation complete. Also, audit all elopements from ED to insure no pts were SI/HI or certified at time of elopement for 3 mths. 5. All ED staff will complete 8 hrs of CPI training initially & recert thereafter: (RNs, CNAs, Security, & Float Staff). Plan developed to insure new staff hired to work in ED will be trained w/in 3 mths of hire. **MOS: 100% Compliance** Current staff will successfully complete 8 hrs of CPI training **50% by 6-30-13; 75% by 7-31-13; & 100% by 12-18-13.** 6. Low Stimulus Unit (LSU) will be adequately staffed to allow this area to be open & available to BH pts where there will be enhanced security presence & monitoring by staff. **MOS: 90% Compliance** **Audit** dates & times that LSU is not open for **3 mths** to determine reason(s).	Pt. Safety: 7/11/13 7/31/13 & Yearly Pt. Safety: 9/13/13 8/31/13 Pt. Safety: 9/12/13; 10/10/13 & 11/14/13 12/18/13 Pt. Safety: 9/12/13; 10/10/13 & 1/2014 5/31/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13

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Z 160	Continued From page 2 patients at that time". The hospital failed to provide 1:1 constant observation in accordance with physician's orders and hospital policy. II. A review of the hospital policy entitled "Fall Precaution Policy, " states under "Policy Statement": "Every adult patient will be assessed for risk of falling on presentation to the Emergency Department and on admission. Reassessment will be completed at least daily; on transfer from one unit to another; following a fall or more frequently as determined by patient status." Under "Policy" it states: Item #3 "Under the direction of the Registered Nurse, the High Risk Interventions will be implemented for patients who are assessed to be a High Fall Risk based on a Schmid score -- 3 or greater. The following actions are required to initiate the program: (a) The Kardex will be stamped High Fall Risk; the numerical score result from the Schmid assessment and the date that assessment was completed will also be entered. (b) Patients who have been assessed to be at High Fall Risk will be further identified by placing a yellow bracelet and yellow slipper socks on the patient." Under "Post Fall Management," it states: Item #6. "Notify the attending physician and the	Z 160	7. Further Education will be provided w/ a mandatory quiz/competency for all RNs. **MOS: 100% Compliance** Completion of competency. **Patient Falls:** 1. Reviewed & revised Fall Prevention Protocol Policy # N-41- improve nsg comprehension of protocol. **-Policy approval** - Nsg Admin. 2. In EMR, add additional queries to safety assessment interventions. 3. In order to be scheduled for work post 6/01/13, all staff must document –Read & Sign revised policy (RNs, CNAs, & MHWs, including PD staff). **MOS: 100%** Required to Read & Sign which will be documented in API Tracking software. 4. Mandatory education for RNs, CNAs & MHWs on policy w/ emphasis on interventions associated w/ high v. low risk assess & documentation (during Skills Weeks) w/quiz. **MOS: 100% Compliance - Staff take quiz.** **Nsg Mgrs Audit: 5 records/wk/unit for 30 days-then mthly** (Documentation of interventions & did intervention fulfill intent) **until Compliance is 100%.** Then auditing will be reassessed. 5. Mandatory Education of Pharm staff on Schmid Fall Risk Assess & meds.	Fall 2013 4/26/13 4/26/13 5/30/13 Pt. Safety: 6/13/13 5/30/13 Pt. Safety: 6/13/13 Pt. Safety: 7/11/13, 9/12/13, 10/10/13 5/13/13

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Z 160	Continued From page 3 family of the fall. This notification can be completed during regular business hours providing the patient has not been injured." Item #7. "Reassess fall risk; review fall prevention interventions that were in place, it any, and modify plan of care as indicated." Item #8. "Document that the patient has fallen on the Kardex, in the SAFETY/RISK FACTOR SECTION and include date and time." 1. A review of the clinical record for patient ID #15 revealed a 76-year-old developmentally delayed patient who was transferred to the hospital from a group home after falling and sustaining a bruise to the right thigh and hip area. The patient was noted to have right sided back pain with swelling and a contusion. Record review indicates a Schmid Fall Risk assessment done in the ED (emergency department) scored the patient as 4 – indicating a "High" falls risk. There lacked evidence of a yellow bracelet or yellow socks placed on the patient in accordance with hospital policy. Additionally, while in the ED on 6/7/12 at approximately 11:30 PM, the patient was being assisted to a wheelchair by a nursing assistant, and suffered a fall which resulted in a fractured femur. Review of the patient's Kardex lacked evidence of the date and time of the fall, and the numerical score from the Schmid Assessment. There also lacked evidence of a falls reassessment after the fall, or any modification to the patient's plan of care. 2. A review of the clinical record for patient ID #32 reveals that the patient was brought to the hospital after tripping and falling at home. The	Z 160	**MOS: Competency Test.** 6. RPh will attend post fall huddles or rev meds w/in 24 hrs post fall. **-RPh interventions tracked & trended** in Meditech - ID if meds contributed to fall. The interventions will be used to determine if med patterns require education & revisions. 7. External expert on geriatric pharm & meds associated w/ falls will be brought in. Goal: to enhance the current Pharm Dept's efforts in conjunction with BH Unit practitioners & staff to provide evidence – based med guidelines for this pt population. **MOS:** Once the suggested guidelines have been created, utilization of guidelines will be initiated in effort to reduce variations. 8. Interactive educational sessions w/ nursing leader of a local skilled facility who has implemented a successful fall reduction plan- initially w/ Falls Comm, then to wider hospital audience. **MOS: Monitor** Fall Rates measured on all hosp units, including ED & outpt areas- Ongoing. **Target: 20% ↓ # of falls 12/2013.** 9. Focus Groups w/ ED, 3S & 4S staff to ID barriers to successfully ↓ # of falls & severity of injuries & address/correct/eliminate barriers as appropriate. **- Report findings** from Focus Groups along w/ resolution(s) or if unable to resolve, discuss next steps. Apply resolutions to other units as appropriate. **-Monitor** individual Unit Fall Rates- Ongoing.	Starting 5/14/13 Pt Safety: Monthly P&T: Ongoing Visit: 7/17/13 Pt. Safety: 9/12/13 for 6 Mths P&T: 9/2013 & Ongoing 6/22/13 - Falls Comm; & 12/30/13 - hosp audience Falls Comm. & Pt. Safety: Mthly 5/30/13 Falls Comm. & Pt. Safety: 6/13/13 Mthly

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Z 160	Continued From page 4 patient was complaining of right knee and hip pain as well as lower back pain. Although the Schmid Fall Risk assessment completed while in the ED revealed a score of 2 (low), the patient's fall risk was documented as "High," indicating that yellow socks and bracelet should be placed on the patient. The patient's ambulatory status was noted to be documented as "unable to ambulate". A "Standard Initial Care" ID Band was applied to the patient. There lacked evidence of a yellow band and yellow socks being placed on the patient. While in the ED the patient suffered a fall in the bathroom while being assisted to the toilet by a Registered Nurse. The patient complained of discomfort in the right lower leg. The patient was lifted from the floor back to a wheelchair and brought back to bed. Review of the ED nursing documentation reveals that the patient complained of right lower leg pain, with the anterior leg slightly red and warm to touch. Motrin was given for pain. The clinical record lacked evidence of a falls reassessment after the fall, with no new falls interventions and evidence that the family was notified of the fall. 3. A review of the clinical record for patient ID #8 revealed a 6/8/12 Schmid Fall Risk assessment which indicates a score of 2, a low risk for falls. At approximately 10:55 PM on 6/9/12 the patient fell while going to the bathroom, hitting her head. Review of the patient's Kardex reveals that the yellow bracelet and yellow slipper socks were not placed on the patient until 6/10/12 at 8:00 AM. The patient "Activity Assessment" following the fall on 6/10/12 at 8:00 AM indicates that the patient activity was "up ad lib." The Kardex also revealed a Schmid Fall Risk reassessment was not done until 6/10/12 at approximately 11:14 AM	Z 160	10. Develop plan & implement expansion of participation in post fall huddles & completion of fall huddle form. **MOS:** **Audit 100% of falls/mth** to determine if a post fall huddle is conducted & if post fall huddle form is completed. **Target 20% ↑/mth. Target: > 90% by 12/2013.** 11. Integrate info into post falls assess in Meditech & MERs. **MOS:** **Audit MERs falls reports weekly** - Insure Mgt completion of Registration/Discovery & Q/PI pgs of MERs. **Target: 20% ↑/mth until 95%.** **Note:** An additional recommendation is being made to require all Geriatric Psychiatry RNs to complete Geriatric Nursing classes offered through CharterCARE Continuum of Care, beginning 9/2013, with the goal of successful completion of Gerontological Nsg Certification Exam by said RNs by 12/2014	6/22/13 Falls Comm. & Pt. Safety: 7/11/13 & Mthly Pt. Safety: 7/11/13 & Mthly

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Z 160	Continued From page 5 and indicates a score of 3 (high), however the Fall Risk is noted to be "low". 4. A review of the clinical record for patient ID #29 revealed that the patient was brought to the ED on 6/4/12 after an unwitnessed fall at nursing home. Review of the Schmid Fall Risk completed in the ED reveals a score of 5, indicating that the patient is a "High" falls risk. The ED documentation also indicates the patient has had multiple falls. The record reveals that a "Standard Initial Care" ID bracelet was placed on the patient. There lacked evidence of a yellow bracelet and yellow socks being placed on the patient in accordance with hospital policy. Review of the patient's Kardex lacked evidence of numerical score of the Schmid Assessment, and also lacked a date and time the assessment was done. 5. A review of the clinical record of patient ID #30 reveals that the patient was brought to the ED from a nursing home for projectile vomiting. The Schmid Fall Risk completed in the ED indicates the patient is a "High" falls risk with a numerical score of 3. A "Standard Initial Care" ID Band was applied. There is no evidence of a yellow band and yellow socks being applied to the patient. When interviewed on 2/19/13 at approximately 11 AM, the Director of Nursing Services and the Clinical Manager of the Emergency Department reported that appropriate interventions for falls risk were not in this patient's chart, and that more interventions should have been put in place, and also indicated there was no reassessment after the patient fell. During an interview with the Risk Manager on 2/27/13 at approximately 11:00 AM, it was	Z 160		

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Z 160	Continued From page 6 reported that if a patient scores "High" on a Falls Risk Assessment, the falls risk should not be documented as "Low."	Z 160		
Z 370	PATIENT CARE SERVICES 19.6 PATIENT CARE MANAGEMENT 19.6 The hospital shall provide care and services to all patients in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to provide care in accordance with community standards, for 3 of 8 patients reviewed (ID #'s 26, 43 and 59), relative to assessment of bowel function on admission and ongoing throughout the hospital stay, and offering laxatives in accordance with standards of care. Findings are as follows: 1. A review of the clinical record for patient ID #26 revealed a 56-year-old admitted to the behavioral health unit on 8/28/12 from a long term care facility with SI (suicidal ideation) and depression. The patient has a past medical history of schizophrenia, seizure disorder, GERD (gastroesophageal reflux disease) and recurrent problems with constipation. A medical consult was performed on 8/31/12. The physical exam revealed a "distended abdomen" and "no normal bowel sounds." A review of the patient's bowel movement record reveals that from 8/29/12 – 9/2/12 (5 days) the patient did not move his bowels, and the PRN (as needed) order for Milk of Magnesia (MOM) was	Z 370	**Assess & Monitor Bowel Function:** 1. Set clear expectations & rev expectations of documentation re: completing bowel assess initially & every shift w/ all RNs of 2 Center. o Rev offer/use of PRN meds in relation indications from bowel assess. **MOS: 100%** of 2 Center RNs will attend mtg re: expectations of bowel assess (sign in sheets.) 2. Mgt will deal w/ findings from audits re: non- compliance by counseling individuals or review & education collectively as appropriate. **MOS: Audit 100% of charts/wk for 3 mth** re: assess of bowel functioning each shift & use of PRN laxatives, as needed **until 95 – 100% compliance; then audit 5 charts/mth - Ongoing.** 3. Add date of last bowel movement to shift - shift Hand Off Report Form. **MOS: 100% of 2 Center RNs** will be educated on revision to shift - shift report form. (sign in sheets.) **MOS: 100% Compliance. Audit observations of 5 Hand offs (on each shift) /mth until 100% compliance** and periodically for hardwiring the process.	5/31/13 Pt. Safety: 6/13/13 6/30/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13 5/13/13 Pt. Safety: 6/13/13 6/30/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13

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Z 370	Continued From page 7 not administered. On the evening of 9/2/12 the patient vomited and was noted to have a markedly distended abdomen. An abdominal film revealed "extensive small bowel and colonic detention with stool in the rectal vault". The impression revealed "the findings may be chronic but this raises the concern of distal colonic obstruction." 2. A review of the clinical record for patient ID #43 reveals an admission to the hospital on 2/4/13 for increased depression. The patient has a physician's order for MOM 30 ml (milliliters) daily, PRN (as needed) for constipation. The patient's bowel movement record revealed that the patient did not move bowels on 2/8 2/9 and 2/10. The MAR (Medication Administration Record) for this patient lacked evidence that the PRN MOM was administered. The patient was discharged on 2/11/13. 3. A review of the clinical record for patient ID #59 reveals an admission to the hospital on 2/13/13 for depression and SI (suicidal ideation). The patient had a physician's order for MOM 30 ml daily, PRN for constipation. The patient's bowel movement record reveals that the patient did not move bowels on 2/14, 2/15 and 2/16. Review of the MAR for this patient lacked evidence that the PRN MOM was administered as ordered. When interviewed on 2/12/13 at approximately 1:30 PM, the Clinical Nursing Manager for the unit, reported that the expectation is for the nurse to assess the patient for bowel sounds and to check what medications are ordered for the patient. She indicated that the MOM should have been administered after the second or third day if no bowel movement.	Z 370		

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Z 375	PATIENT CARE SERVICES 19.7 PATIENT CARE MANAGEMENT 19.7 Medical Restraints: In acute medical and pre/post-surgical care, a patient shall be free from physical and chemical restraint that is not medically necessary. A restraint shall only be used if needed to improve the patient's well-being and only if less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. Behavioral Restraints: A patient shall be free from seclusion or restraint imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint employed for behavior management shall only be used in emergency situations if needed to ensure the patient's or other's physical safety and less restrictive interventions have been determined to be ineffective. 19.7.1 Restraints/seclusion use shall be prescribed in writing and signed by a physician or other licensed practitioner acting within his/her scope of practice and permitted by the hospital to order restraints/seclusion. The type and duration of restraints/seclusion shall be specified. Standing or "on an as needed basis" (i.e., PRN) orders shall not be permitted. 19.7.2 Restraints/seclusion, if used, shall be addressed in the written treatment plan for the patient. 19.7.3 Restraints/seclusion use shall be based on an assessment of the patient, implemented in the least restrictive manner possible, implemented in accordance with safe and appropriate restraining techniques, and discontinued at the earliest possible time. 19.7.4 The condition of a restrained/secluded patient shall be continually assessed, monitored, and revaluated.	Z 375	**Use of a Chemical Restraint in The ED:** 1. All ED staff including RNs, LIPs & MDs will Read & Sign Restraint Seclusion & Restraint Alternatives Policy #04.953.282. **MOS: 100% Compliance** (sign in sheets.) 2. Develop education re: definition of chem restraint; ways to approach pt inclusive of MH Laws (vol v. invol admin of med); providing guideline scripts for staff; what to do when a pt lacks capacity; clarifying use of a chem restraint in ED; & appropriate documentation of a chem restraint. This event will be presented as a case study. Points to consider: use of chem. restraint; Pt Rts; & alternative methods. 3. All ED RNs, LIPs & MDs will attend & participate in above education. **MOS: 100% Compliance** (sign in sheets.) 4. Develop & present 4 case studies (ED scenarios) at clinical mtgs w/ all RN staff where staff actively present scenarios & participate in discussion of ways to handle additional situations. **MOS: 100% Compliance** (sign in sheets.) 5. Pharm will conduct a 14 day retrospective review of Haldol use in ED to obtain baseline of Haldol utilization & provide data to ED Mgr, who w/ assistance of Med Dir of ED, will review the data to insure there are no trends involving Haldol use for chem restraint. 6. Current restraint audit tool will now include appropriate use of chem restraints as well as	5/31/13 Pt. Safety: 6/13/13 5/31/13 6/30/13 Pt. Safety: 7/11/13 7/31/13 Pt. Safety: 9/12/13 5/6/13 6/30/13 6/30/13

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Z 375	Continued From page 9 This Requirement is not met as evidenced by: Based on review of the clinical record and staff interview it has been determined that the hospital failed to ensure that less restrictive interventions and/or alternatives had been employed and ineffective prior to chemically restraining 1 of 6 patients with a change in mental status. (ID#6) Findings are as follows: A review of the clinical record for patient ID #6 reveals a transport to the hospital on 9/9/12 from an Assisted Living Facility (ALF) for a change in mental status. Review of the COC (Continuity of Care) form from the ALF revealed "Patient change in mental status. Acting out upon staff and other residents even after PRN (as needed) Ativan given". The patient has a past medical history of HTN (hypertension), Bipolar disorder, Parkinsonism and Schizophrenia. The patient was placed on constant observation in the ED, and was evaluated by a behavioral health center. The assessment indicated that an inpatient admission would not be appropriate as the "...pt does not appear to be exhibiting extreme behaviors that are out of norm. Pt does not meet inpatient criteria at this time." The patient remained in the ED until his discharge on 9/10/12. The ED record reveals that the patient's behavior during his observation period was "alert and oriented and often times sleeping". When awake, the patient was noted to have appropriate behavior and was "relaxed and cooperative". On 9/10/12 at approximately 1920 (7:20 PM) the patient was noted to be yelling and swearing regarding not leaving the hospital. The patient requested to stay in the hospital "because he	Z 375	phys restraints. **MOS:** **Audit 100% of restraints used** (including chem restraint use) **in ED/mth for a min of 3 mths until compliance is 100%.** Then determination to be made for future monitoring.	Pt. Safety: 9/12/13

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Z 375	Continued From page 10 likes it better here". Record documentation revealed "MD in to talk with Pt. and was yelled at. MD ordered 10mg Haldol IM (intramuscular) and given." The patient was noted to continue to yell and was subsequently administered 2 mg of Ativan and 50 mg of Dipenhydramine IM as ordered. The Haldol was administered at 7 PM and the Ativan and Dipenhydramine were both administered at 7:19 PM. The patient left the facility at 7:40 PM. When interviewed on 1/25/13 at approximately 12:30 PM, the nurse who administered the medications indicated the patient was fine during the shift. It was when the patient was told that he/she would be returning to the ALF that he/she became verbal and argumentative, but not physically aggressive. The nurse revealed that the patient calmed down after administration of all above medications, and remained non-combative and cooperative while waiting for the ambulance. Interview on 1/29/13 at 1:00 PM with the PA (Physician's Assistant) who ordered the medication, revealed that the patient was calm and non-combative, and receiving his regularly scheduled medications. The patient reportedly only became agitated when EMS (Emergency Medical Services) arrived, at which point the patient began yelling and escalated and was unable to calm down; he was medicated and did calm down after about 10 minutes. When asked if any of the patient's discharge medications were changed, the PA stated "no, all of the patient's medications he was receiving before coming to the ED remained the same". When interviewed on 1/31/13 at 9:00 AM, the licensed clinical social worker from the behavioral health center who evaluated the patient indicated	Z 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING:_____ B. WING_____	03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

(X) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC INDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 375	Continued From page 11 that the patient's behavior was fine, he was cooperative, non combative and not physically aggressive. It was based on this evaluation that the patient was deemed appropriate to discharge back to the ALF. There was no evidence that the patient had been physically aggressive or combative during his stay in the ED. There was no evidence that alternative or less restrictive methods were tried prior to administering the chemical restraint.	Z 375		
10	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on review of hospital occurrence reports submitted to the Department of Health, and staff interview, it was determined that the hospital failed to report to the licensing agency, within 72 hours, reportable incidents/event for 5 of 18 relevant sample patients (ID #'s 52, 55, 61, 62 and 63) Findings are as follows: 1. A reportable incident occurring for patient ID #52 on 12/4/12 was not reported to the licensing agency until 12/15/12. 2. A reportable incident occurring for patient ID #55 on 11/16/12 was not reported to the licensing	Z 940	**Late Reporting of Incidents (Crowley Bill) to DOH:** 1. Review & revise Incident Reporting Policy #03-957-03. 2. Review & revise Hosp Incident/Events Reporting to RI DOH Policy #01-950-83. 3. Develop & present Education at Nsg Leadership & Nsg Supervisors re: revisions to policies; types of events to be reported & importance of timely reporting in MERs by end of shift; & type of info initially needed to include in MERs. RM will provide Talking Points for Mgrs re: Types of events/incidents reportable w/in 24-72 hrs of event; Mgr/Dir/ Supervisor to page RM for all incidents resulting in major harm/death/a sentinel events and call or voice msg RM for all events that result in moderate harm; & all depts w/ paper MR to provide copies of applicable sections of MR to RM via fax w/in 24 hrs of a reportable incident. **MOS: 100 % Compliance** - Attendance (sign in sheets.)	5/31/13 5/31/13 6/30/13 Pt. Safety: 7/11/13

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING:_____ B. WING_____	03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

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Z 940	Continued From page 12 agency until 11/30/12. 3. A reportable incident occurring for patient ID #61 on 8/7/12 was not reported to the licensing agency until 9/25/12. 4. A reportable event occurring for patient ID #62 on 9/26/12 was not reported to the licensing agency until 10/3/12. Continued From page 12 5. A reportable incident occurring for patient ID #63 on 9/14/12 was not reported to the licensing agency until 10/3/12. During an interview on 3/5/13 at approximately 1:30 PM with the Risk Manager, she was unable to provide evidence that the above incidents/event were reported to the licensing agency within 72 hours.	Z 940	4. Nsg Mgrs/Dir hold staff mtgs w/RNs to rev presentation presented at Leadership, Read & Sign policies & have all RNs complete a PP competency & quiz on types of incidents that should be reported in MERs including but not limited to "Crowley Bill" DOH reportable incidents & timely reporting in MERs during shift in which incident occurred. **MOS: 100% Compliance of Nsg units** – hold meeting w/ RNs (minutes from mtgs.) **MOS: 100% of all RNs** will Read & Sign policies which will be documented in API tracking software. **MOS: 100% Compliance**- all RNs complete PP & quiz, which will be documented in API tracking software. 5. RM to provide Education to specific areas w/ high non-compliance identified by baseline audits. Areas of non-compliance will be identified by baseline audit of 100% of DOH reports - 4th Q 2012 & 1st Q 2013. 6. Claims Coord/ MERs Adm will increase hrs from 20 to 40 hr/week in RM Dept - taking on responsibilities that do not require clinical judgment. 7. RM Dept will only include essential elements in initial report/notification to DOH. **MOS: 95% - 100% Compliance**-timely reporting to DOH. **Audit: 100% of DOH** reports/mth for untimeliness of reporting & reasons. Develop action plans accordingly.	7/31/13 Pt. Safety: 9/12/13 Pt. Safety: 9/12/13 Audits: 7/11/13 Pt. Safety: 7/11/13 5/1/13 Ongoing Pt. Safety: 7/11/13 & Mthly until 95-100%

Department of Health
Three Capitol Hill
Providence, RI 02908-5097
TTY: 711
www.health.ri.gov

Received
SEP 30 2013
Kenneth H. Belcher
President / CEO

September 24, 2013

Mr. Kenneth Belcher, President/CEO
Roger Williams Medical Center
825 Chalkstone Avenue
Providence, RI 02908

Dear Mr. Belcher:

This office has received the Plan of Correction for the deficiencies cited as a result of our review completed on August 20, 2013. The provisions and time frames for your corrective action is determined to be acceptable.

Please note that a member of the Facilities Regulation staff will make an unannounced site visit to the hospital to ensure compliance has been achieved.

If you have any questions, please contact Madeline Vincent at 401-222-2566.

Sincerely,

Raymond Rusin, Chief
Facilities Regulation
(401) 222-2566

MV

CharterCARE
HEALTH PARTNERS

WWW.CHARTERCARE.ORG

September 13, 2013

Raymond Rusin
Chief Facilities Regulation
Department of Health
Three Capitol Hill
Providence, RI 02908-5097

RE: Investigation completed on August 20, 2013

Dear Mr. Rusin:

This is in response to your correspondence to me dated August 29, 2013 in regards to our hospital not being in compliance with the Rules and Regulations for Licensing of Hospitals and corresponding citations noted on the enclosed Statement of Deficiencies (State Form).

Please see our plan of correction on the State Form (Provider's Plan of Correction) with the date of completion, signed and dated as per your request.

Should you have any questions please feel free to call myself at 456-2025 or Joyce Hackley, Director, Risk Management at 456-2405.

Sincerely,

Kenneth H. Belcher
President/CEO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING _____ B. WING _____	8/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEBYFULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
Z 115	ORGANIZATION & MANAGEMENT 9.5 Quality Improvement	Z 115	**Plan:** All reportable incidents under 23-17-40 Hospital Event Reporting will be reported to the Department of Health (DOH) within seventy-two (72) hours. All incidents will be presented to the appropriate committee within the hospital and have a peer review performed, with notification back to the DOH within 6 months from the date of the initial report. **Do:** **Patient ID #33** related to an incident occurring on 12/5/2012 was brought to the appropriate peer review committee on August 29, 2013. Once the peer review is received it will be presented to the peer review committee and the DOH will be notified of the outcome of the internal review as soon as the information is made available as is our usual practice. **Check:** Committee minutes will reflect the discussion by the members of the peer review and the outcome. Follow-up report will be sent to the DOH via Health's secured web file repository. Confirmation of file will be attached to hospital copy of the Follow-up report that was sent. A log will be kept in Risk Management to track the date of the incident, date sent to the DOH, date incident brought to the peer review committee and date closed.	10/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9/13/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING _____ B. WING _____	8/20/13

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

Z 940	PATIENT CARE SERVICES 34.8 Reportable Incidents	Z 940	**Plan:** All reportable incidents under 23-17-40 Hospital Event Reporting will be reported to the Department of Health (DOH) within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. **Do :** **Patient ID #'s 15, 34, 35, 36 & 37** and all other incidents that the hospital decides to report to our malpractice insurance carrier will be reported to the DOH within 72 hours of us reporting the incident to our malpractice insurer unless the incident met one of the reporting requirements other than "reported to the malpractice insurance carrier". We will explain in the brief description of the Hospital Incident reporting form the reason for the difference in the date of the report and the incident date. Our records reveal that **ID#37** has a date of incident of 10/4/12; decision made to report to our malpractice insurer as a precautionary measure on 10/24/12 and reported to the DOH on 10/24/12. Hospital Incident reporting form asked to be resent to the DOH on 11/2/12. See attachment #1. **Check:** Documentation of the reason that the date of the incident and the reported date are greater than 72 hours within the brief description of the Hospital Incident reporting form. A log will be kept in Risk Management to track the date incident was reported to the malpractice insurer and the date the incident was reported to the DOH when the date reported to the DOH is greater than 72 hours from the date of the incident.	9/26/13

CEO 9/13/13

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

Z 950	PATIENT CARE SERVICES 34.10 Reportable Incidents	Z950	**Plan:** The hospital shall notify the licensing agency of the outcome of the internal review as soon as this information is available but no later than six (6) months after the initial report. **Do:** A "Follow-up Report" will be submitted to the licensing agency within the six (6) month time period after the submission of the initial report via Health's secured web file repository. **Check:** Monthly follow-up calls and written correspondence to all peer reviewers if the review has not been received to date. Documentation of actions will be kept with all individual incident minutes. Untimely return of the peer review by the requested reviewer will be reported to the Quality Department every three months and will be tied to the OPPE process which is tied to the reappointment process.	9/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | CEO | 9/13/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RHODE ISLAND DEPARTMENT OF HEALTH

Department of Health
Three Capitol Hill
Providence, RI 02908-5097
TTY: 711
www.health.ri.gov

Received
SEP 03 2013
Kenneth H. Belcher
President / CEO

August 29, 2013

Mr. Kenneth Belcher, Administrator
Roger Williams Medical Center
825 Chalkstone Avenue
Providence, RI 02908

Re: Investigation completed on August 20, 2013

Dear Mr Belcher:

This letter is a follow-up to an investigation completed at Roger Williams Medical Center on August 20, 2013. This visit included, but was not limited to, investigation of complaints regarding allegations of non-compliance.

Please note the following results for the related Intake ID number (see roster):

RI00027232 - Unsubstantiated
RI00027802 - Unsubstantiated
RI00028701 - Unsubstantiated
RI00029009 - Unsubstantiated
RI00029236 - Unsubstantiated
RI00029502 - Unsubstantiated
RI00029734 - Unsubstantiated
RI00029790 - Unsubstantiated
RI00030644 - Unsubstantiated
RI00030846 - Unsubstantiated
RI00030991 - Unsubstantiated
RI00031101 - Unsubstantiated
RI00031152 - Substantiated, no deficiency
RI00031646 - Unsubstantiated
RI00032154 - Unsubstantiated
RI00033013 - Unsubstantiated
RI00033520 - Unsubstantiated
RI00033622 - Unsubstantiated
RI00033744 - Substantiated, no deficiency
RI00033825 - Unsubstantiated
RI00033936 - Unsubstantiated
RI00034203 - Unsubstantiated
RI00035588 - Unsubstantiated
RI00035803 - Unsubstantiated

This survey found that your facility was not in compliance with the Rules and Regulations for Licensing of Hospitals and citations are noted on the enclosed Statement of Deficiencies (State Form). A plan of correction is required and must be submitted to this office by September 13, 2013. Please enter, in the right hand column of the State Form (Provider's Plan of Correction), your response to each citation with a date of completion (X5 complete date), sign (X6 Date) and return to this office by September 13, 2013.

Your Plan of Correction must contain the following:

· What corrective actions will be accomplished for those patients/situations found to have been affected by the deficient practice;

· How you will identify other patients/situations having the potential to be affected by the same deficient practice and what corrective action will be taken;

· What measures will be put into place of what systemic changes you will make to ensure that the deficient practice does not recur; and,

· How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

If you have any questions regarding this issue, please call Deborah Massaniso RN SNCE at 401-222-4529..

Thank you for the courtesy extended to our survey staff during this investigation.

Sincerely,

Raymond Rusin, Chief
Facilities Regulation

DM

RI Department of Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING: _____ B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z 0	INITIAL COMMENTS An 'Other' State licensure survey and a State complaint investigation survey (67DO11, 8/30/13) were conducted at this facility. Deficiencies were cited relative to the 'Other' State licensure survey.	Z 0		
Z 115	ORGANIZATION & MANAGEMENT 9.5 Quality Improvement 9.5 All medical and surgical services performed in the hospital shall be evaluated for appropriateness in diagnosis and treatment. The evaluation shall include peer review of individual cases. The hospital shall maintain records of peer reviews, documenting the case(s) reviewed, focus of each review, findings, conclusions, any actions taken, and any follow-up on actions taken. This Requirement is not met as evidenced by: Based on document review and staff interview, it was determined the hospital failed to ensure that a peer review was performed to evaluate for appropriateness in diagnosis and treatment for 1 of 4 relevant sample patients (ID #33). Findings are as follows: The hospital was unable to provide evidence of a peer review for patient ID #33 related to an incident occurring on 12/5/2012. Interview on 8/19/2013 at approximately 12 PM with the Director of Risk Management, revealed a peer review had not been obtained.	Z 115		
Z 940	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or	Z 940		

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING: _____ B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z 940	Continued From page 1 after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on review of hospital occurrence reports submitted to the Department of Health and staff interview, it was determined that the hospital failed to report to the licensing agency, within 72 hours, reportable incidents for 5 of 7 relevant sample patients (ID #s 15, 34, 35, 36 and 37). Findings are as follow: 1. A reportable incident occurring for patient ID # 15 on 9/28/2012 was not reported to the licensing agency until 10/30/2012. 2. A reportable incident occurring for patient ID # 34 on 11/2/2012 was not reported until 11/16/2012. 3. A reportable incident occurring for patient ID # 35 on 9/11/2012 was not reported until 9/21/2012. 4. A reportable incident occurring for patient ID # 36 on 9/19/2012 was not reported until 10/10/2012. 5. A reportable incident occurring for patient ID # 37 on 10/4/2012 was not reported until 10/24/2012. During an interview with the Director of Risk Management on 8/19/2013 at approximately 12 PM, she was unable to provide evidence that the	Z 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 940	Continued From page 2 above incidents were reported to the licensing agency within the required 72 hours.	Z 940		
Z 950	PATIENT CARE SERVICES 34.10 Reportable Incidents 34.10 The hospital shall ensure an appropriate committee or multidisciplinary group conducts peer review for all reportable incidents. The hospital shall notify the licensing agency of the outcome of the internal review as soon as this information is available but in no case later than six (6) months after the initial report and if the findings determine that the incident was within the normal range of outcomes, no further action shall be required. This Requirement is not met as evidenced by: Based on review of hospital reportable incidents and staff interview, it was determined that the hospital failed to notify the licensing agency, no later than 6 months after the initial report, of the outcome of the peer review for 1 of 7 relevant sample patients (ID #6) Findings are as follows: A review of the hospital's incident reports filed with the Department of Health revealed that the hospital reported the incident, but failed to submit to the licensing agency the " Follow-up Report" within the required time frame of 6 months. A " Follow-up Report " for an incident occurring on 1/4/2012, was not made available to the licensing agency until 8/12/2012. During an interview on 8/19/2013 at approximately 12 PM, the Director of Risk Management was unable to provide evidence that	Z 960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z 950	Continued From page 3 a "Follow-up Report" had been submitted to the licensing agency within the 6 month time frame as required.	Z 950		

EXHIBIT Q48-1

CHARITY AND COLLECTION POLICIES (WATERBURY HOSPITAL)

POLICY: CHARITY CARE		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 3
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 12/5/97 (From PAFS manual)
LAST REVIEWED: 11/11	LAST REVISED: 8/13	RETIRED:

SCOPE: Determination of when charity care is appropriate.
PURPOSE: To make provisions for situations in which charity care is appropriate based on aggregate balance and Encounter review.

POLICY: It is the policy of Waterbury Hospital to appropriately offer charity care in situations where the responsible party for the balance due does not have the financial resources necessary to satisfy their obligation within a reasonable period of time.

1. All patients who request consideration for charity care will be required to apply for public assistance in addition to completing a charity care application unless identified as ineligible by a qualified case worker.

2. In order to be considered for charity care, full financial disclosure is required including:
    a. All sources of income available at the time of application;
    b. Assets excluding;
        i. Primary Residence;
        ii. Vehicles required for commuting to or facilitating employment;
        iii. Retirement Accounts.

3. Responsible parties with assets of $7,500 or less ($15,000 for a couple) will receive the following discounts based on their annual household income and the published federal poverty guidelines in effect at the date of application:

Income as a % of FPL	Discount
<200%	100%
<= 225%	60%
<= 275%	40%
<= 300%	20%
<= 400%	10%

4. Charity care discounts are to be applied after the 50% uninsured discount from charges.

5. Documentation required to validate declarations made on the charity care application shall include:
    a. A credit report;
    b. Most recent 1040 tax return;
    c. Copies of all bank statements to include but not limited to:
        i. Checking accounts;
        ii. Savings accounts;
        iii. Investment accounts;
        iv. Certificates of deposit
    d. Proof of income for the immediate 12 months preceding the application date.
    e. Public assistance determination.

PROCEDURE:

1. The availability of charity care will be disclosed on all dunning notices issued prior to bad debt assignment.

2. Patients who indicate they are unable to pay for services rendered will be offered charity care;

3. Financial Counselors shall evaluate each applicant's eligibility.

4. Accounts determined to be eligible for charity care discounts shall require the following authorization based on amount to be adjusted:
   a. PAFS Manager < $5,000
   b. PAFS Director $5,000 or more
   c. Chief Financial Officer $10,000 or more

5. Patients shall be issued a determination letter within 30 days of receipt of a completed charity care application.

6. Patients who do not apply for or do not qualify for charity care will be expected to pay the balance due. For uninsured patients, this will be equivalent to 50% of charges. Insured patients will be expected to pay any deductible or co-payment due in addition to 50% of non-covered charges.

7. Patient who do not enter into a payment plan or pay satisfy the balance due will be placed with a collection agency for further collection efforts. The collection agency may report the balance due to credit reporting bureaus and/or initiate legal action to resolve the debt.

Approved: _____ 8/8/13
Mark Sammartano
Director, PAFS
Date

Approved: _____ 2/12/2014
CFO/VP Finance
Date

POLICY: POINT OF SERVICE COLLECTIONS

CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PAFS		ORIGINATED: 10/01/2015
LAST REVIEWED:	LAST REVISED:	RETIRED:

SCOPE: This policy covers all elective and scheduled services.

PURPOSE: The purpose of this policy is to establish processes and procedures that will enable the facility to manage discretionary bad debt.

POLICY:

1. It is the policy of Greater Waterbury Hospital to treat all patients who require urgent care regardless of their ability to pay for services.

2. Patients who present for urgent care shall receive a medical screening examination and be stabilized prior to any discussion regarding payment for services.

3. Patients who wish to schedule elective services and have a history of bad debt, are likely to be responsible for 50% or more of the estimated cost of care, or will have an out-of-pocket balance due of $500 or more will be expected to establish satisfactory payment terms prior to being scheduled for services.

4. The hospital will continue to offer free care and discounted care to eligible patients based on the Federal Poverty Limits published annually (see Administrative Policy "Charity Care").

PROCEDURE:

Upon receiving a scheduling request, the scheduler shall evaluate the patient's estimated out-of-pocket balance, any current balances due, as well as bad debt balances due to determine if the patient will be required to enter into a satisfactory payment plan.

1. If a co-pay/deductible is required, the verification staff will require the following payment options:

   - If the patient's co-pay/deductible is over $500.00, the patient will minimally be responsible to pay 50% of the co-pay/deductible amount prior to the scheduled service date. The remaining patient balance may be placed into a payment arrangement of four to six months.

   - If the patient's co-pay/deductible is under $500.00, the patient will minimally be responsible to pay 50% of the co-pay/deductible amount. The remaining patient balance may be placed into a payment arrangement of up to three months.

2. If the patient has had previous bad debt accounts within the past two years, the patient will be classified as a credit risk and will be required to pay 100% of the co-pay/deductible prior to the scheduled admission/procedure date.

3. If any required payment is not satisfied, the patient will be informed that the physician's office will be contacted to determine whether the procedure can be rescheduled or cancelled. Patients will be notified within one day if the physician's office does cancel or reschedule the admission/procedure.

4. If the physician's office declines to cancel because of medical necessity, the admission/procedure will proceed as scheduled. All cases identified with this occurring will be subject for review by the hospital's utilization management staff.

5. Patients shall not be eligible for prompt pay discounts if they have prior outstanding balances or are making a partial payment for estimated balances due.

POINT OF SERVICE COLLECTIONS

Approved: _____ _____
Mark Sammartano Date
Director, PAFS

Approved: _____ _____
James Moylan Date
CFO/VP Finance

POLICY: UNINSURED PATIENT DISCOUNT		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 4/13
LAST REVIEWED: 4/15	LAST REVISED:	RETIRED:

SCOPE: All PFS and Patient Access staff.
PURPOSE: To align balances due from uninsured patients with payments received from insurance carriers

POLICY:

1. Uninsured patients shall be entitled to a discount of 50% of charges.
2. This discount shall be posted to the patient's account at the time a final bill is generated.
3. Any additional discounts such as prompt pay or charity care shall be calculated after the uninsured discount is applied.
4. Accounts forwarded to collections shall be placed net of the uninsured discount.

PROCEDURES:

1. Posting of the uninsured discount shall be automated through the HIS in place at the time the bill is generated.
2. In the event insurance coverage is identified after the uninsured adjustment has been posted, the adjustment shall be reversed and any applicable contractual allowance posted as per standing protocol for the specific payer.

UNINSURED PATIENT DISCOUNT

Approved: _____ _____
Mark Sammartano Date
Director, PAFS

Approved: _____ _____
Edward Romero Date
CFO/VP Finance

POLICY: PROMPT PAY DISCOUNT		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 4/13
LAST REVIEWED:	LAST REVISED:	RETIRED:

SCOPE: Billing practices for uninsured patients.
PURPOSE: To establish an equitable method of billing uninsured patients considering insurance reimbursement practices.

POLICY:

1. In order to reduce the cost of collections and increase the availability of working capital, a 25% discount will be offered to patients who pay the estimated balance due on or before the date of service.

2. Uninsured patients shall receive this discount in addition to any uninsured discounts effective at the time of service.

3. Insured patients shall receive this discount if payment is received at time of service based on an estimate of their out-of-pocket expenses. This discount shall be extended to any additional balances due in the event the estimated balance is less than the actual amount due after the claim has been paid by the insurance carrier provided the remaining balance is paid within 30 days of the first patient bill.

PROCEDURES

1. Non-urgent patients shall be notified of their estimated balance due prior to receiving services to include open AR and unresolved bad debt balances.

2. Urgent patients shall be notified of their estimated balance due, including unresolved active AR and bad debt, after their medical condition has been stabilized.

3. A 25% discount shall be extended to any portion of the debt paid by the patient upon notification of the total estimated balances due to the hospital.

4. Upon collection of payment, a receipt for the amount tendered will be issued with the discount clearly documented.

5. The white copy of the receipt will be given to the patient for their records.

6. The pink copy will be forwarded to the cashier with the funds for posting both payment and the discount.

7. The yellow copy will be retained in the receipt book at the department.

8. Upon depletion of a receipt, it will be the department's responsibility to archive these books in accordance with existing document retention policies.

Approved: _____ _____
Mark Sammartano Date
Director, PAFS

Approved: _____ _____
Date
CFO/VP Finance

EXHIBIT Q50-1

OHCA FINANCIAL STATISTICS REPORT (GWHN)

Waterbury Hospital Only

	Month of Apr-14	Y-T-D 04/30/14	Month of Apr-15	Y-T-D 04/30/15	Month of May-14	Y-T-D 05/31/14	Month of May-15	Y-T-D 05/31/15	Month of Jun-14	Y-T-D 06/30/14	Month of Jun-15	Y-T-D 06/30/15
A. Operating Performance												
Operating Margin	5.60%	1.61%	-19.90%	0.10%	0.43%	1.46%	-10.73%	-1.14%	-11.48%	0.08%	-1.87%	-8.19%
Non-Operating Margin	6.35%	3.31%	-18.84%	1.40%	1.28%	3.05%	-9.85%	0.12%	-10.61%	1.59%	-0.65%	-7.25%
Total Margin	6.45%	3.33%	-18.87%	1.39%	1.34%	3.08%	-9.26%	0.18%	-10.59%	1.62%	-0.60%	-7.28%
Bad Debt as % Gross Revenue	-1.93%	0.19%	-1.66%	0.25%	4.63%	0.77%	0.51%	0.28%	-2.12%	0.45%	0.27%	0.14%
B. Liquidity												
Current Ratio	1.98	1.98	1.91	1.91	2.14	2.14	1.78	1.78	1.76	1.76	1.57	1.57
Days Cash on Hand	55.26	55.26	47.96	47.96	47.98	47.98	48.92	48.92	56.02	56.02	49.69	49.69
Days in Net Accounts Receivables	45.90	45.90	53.87	53.87	47.39	47.39	56.93	56.93	52.00	52.00	64.03	64.03
Average Payment Period	42.43	42.43	40.44	40.44	37.41	37.41	44.23	44.23	45.27	45.27	48.01	48.01
C. Leverage and Capital Structure												
Long-term Debt to Equity	1.4726	1.4726	3.5670	3.5670	1.5234	1.5234	5.3177	5.3177	1.7923	1.7923	10.2958	10.2958
Long-term Debt to Capitalization	0.5956	0.5956	0.7810	0.7810	0.6037	0.6037	0.8417	0.8417	0.6419	0.6419	0.9115	0.9115
Unrestricted Cash to Debt	0.7518	0.7518	0.4701	0.4701	0.5595	0.5595	0.4864	0.4864	0.6347	0.6347	0.5132	0.5132
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	3.07	3.07	-0.48	-0.48	2.38	2.38	-1.44	-1.44	1.73	1.73	-1.30	-1.30
Equity Financing Ratio	4.19	4.19	11.00	11.00	4.16	4.16	16.95	16.95	5.37	5.37	34.37	34.37
D. Additional Statistics												
Income from Operations	1,762,320	6,832,700	(2,229,359)	4,498,875	762,995	7,595,695	(1,076,954)	3,421,921	(1,287,050)	6,308,645	2,713,577	(708,344)
Revenue Over/(Under) Expense	1,244,562	4,206,710	(2,707,054)	1,720,164	242,785	4,449,495	(1,472,455)	247,709	(1,825,125)	2,624,370	(935,379)	(1,183,088)
EBITDA	1,762,320	6,832,700	(2,229,359)	4,498,875	762,995	7,595,695	(1,076,954)	3,421,921	(1,287,050)	6,308,645	2,713,577	(708,344)
Patient Cash Collected	19,133,328	122,616,001	16,344,751	116,992,804	16,933,631	139,549,632	15,045,288	132,038,092	16,713,514	156,263,146	148,192,895	16,154,803
Cash and Cash Equivalents	20,455,135	20,455,135	12,227,335	12,227,335	15,179,232	15,179,232	12,575,558	12,575,558	17,172,188	17,172,188	13,229,814	22,002,562
Net Working Capital	27,070,632	27,070,632	24,721,814	24,721,814	27,175,476	27,175,476	22,746,727	22,746,727	23,123,042	23,123,042	18,291,590	18,291,590
Unrestricted Assets	17,899,467	17,899,467	7,044,328	7,044,328	17,257,757	17,257,757	4,697,030	4,697,030	14,629,775	14,629,775	2,418,973	2,418,973
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Waterbury Hospital Only

	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15
A. Operating Performance								
Operating Margin	-1.23%	-0.06%	-18.30%	-3.40%	-3.87%	-0.40%	-10.44%	-4.01%
Non-Operating Margin	-0.22%	1.40%	-17.27%	-2.20%	-2.41%	1.06%	-9.51%	-2.83%
Total Margin	-0.19%	1.43%	-17.34%	-2.16%	-2.36%	1.10%	-9.58%	-2.80%
Bad Debt as % Gross Revenue	-3.18%	0.09%	1.03%	0.35%	0.77%	0.15%	0.86%	0.39%
B. Liquidity								
Current Ratio	1.73	1.73	1.53	1.53	1.91	1.91	1.56	1.56
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69
C. Leverage and Capital Structure								
Long-term Debt to Equity	1.9083	1.9083	-23.7088	-23.7088	2.0337	2.0337	-6.2679	-6.2679
Long-term Debt to Capitalization	0.6562	0.6562	1.0440	1.0440	0.6704	0.6704	1.1898	1.1898
Unrestricted Cash to Debt	0.7582	0.7582	0.3218	0.3218	0.6156	0.6156	0.2694	0.2694
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31
Equity Financing Ratio	5.81	5.81	-76.40	-76.40	5.95	5.95	-20.33	-20.33
D. Additional Statistics								
Income from Operations	447,817	6,756,462	(2,301,275)	412,302	4,351	6,760,813	(1,055,933)	(643,631)
Revenue Over/(Under) Expense	(35,827)	2,588,543	(2,772,128)	(3,707,507)	(416,695)	2,171,848	(1,547,662)	(5,255,169)
EBITDA	447,817	6,756,462	(2,301,275)	412,302	4,351	6,760,813	(1,055,933)	(643,631)
Patient Cash Collected	16,953,790	173,216,936	17,588,030	165,780,926	16,391,215	189,608,151	16,367,950	182,148,876
Cash and Cash Equivalents	20,457,074	20,457,074	3,010,785	8,257,373	16,563,273	16,563,273	2,978,798	6,880,235
Net Working Capital	22,842,265	22,842,265	15,242,354	15,242,354	25,043,856	25,043,856	16,052,250	16,052,250
Unrestricted Assets	13,704,068	13,704,068	(1,045,742)	(1,045,742)	12,825,022	12,825,022	(3,936,749)	(3,936,749)
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Total GWHN

	Month of Apr-14	Y-T-D 04/30/14	Month of Apr-15	Y-T-D 04/30/15	Month of May-14	Y-T-D 05/31/14	Month of May-15	Y-T-D 05/31/15	Month of Jun-14	Y-T-D 06/30/14	Month of Jun-15	Y-T-D 06/30/15
A. Operating Performance												
Operating Margin	3.34%	-1.72%	-16.32%	-3.57%	-2.55%	-1.77%	-13.33%	-4.69%	-11.69%	-2.85%	-10.80%	-5.33%
Non-Operating Margin	4.03%	-0.30%	-15.54%	-2.53%	-1.83%	-0.44%	-12.63%	-3.68%	-10.94%	-1.58%	-10.06%	-4.35%
Total Margin	4.24%	-0.13%	-17.66%	-2.72%	-0.92%	-0.17%	-12.14%	-3.80%	-10.70%	-1.32%	-11.09%	-4.57%
Bad Debt as % Gross Revenue	-1.67%	0.26%	-1.43%	0.31%	4.33%	0.79%	0.53%	0.33%	-1.93%	0.49%	0.21%	0.32%
B. Liquidity												
Current Ratio	1.91	1.91	1.74	1.74	1.99	1.99	1.62	1.62	1.69	1.69	1.45	1.45
Days Cash on Hand	55.26	55.26	47.96	47.96	47.98	47.98	48.92	48.92	56.02	56.02	49.69	49.69
Days in Net Accounts Receivables	45.90	45.90	53.87	53.87	47.39	47.39	56.93	56.93	52.00	52.00	64.03	64.03
Average Payment Period	42.43	42.43	40.44	40.44	37.41	37.41	44.23	44.23	45.27	45.27	48.01	48.01
C. Leverage and Capital Structure												
Long-term Debt to Equity	0.6687	0.6687	0.9854	0.9854	0.6754	0.6754	1.0831	1.0831	0.7215	0.7215	1.2112	1.2112
Long-term Debt to Capitalization	0.4007	0.4007	0.4963	0.4963	0.4031	0.4031	0.5200	0.5200	0.4191	0.4191	0.5478	0.5478
Unrestricted Cash to Debt	1.0331	1.0331	0.7666	0.7666	0.8446	0.8446	0.7939	0.7939	0.9274	0.9274	0.8521	0.8521
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	3.07	3.07	-0.48	-0.48	2.38	2.38	-1.44	-1.44	1.73	1.73	-1.30	-1.30
Equity Financing Ratio	2.02	2.02	3.20	3.20	1.96	1.96	3.65	3.65	2.28	2.28	4.26	4.26
D. Additional Statistics												
Income from Operations	1,561,156	2,776,068	(2,462,226)	(597,021)	193,077	3,070,117	(1,965,465)	(2,562,482)	(1,751,406)	1,318,712	(1,527,890)	(4,088,302)
Revenue Over/(Under) Expense	1,009,561	(200,371)	(3,416,236)	(4,210,292)	(208,023)	(307,422)	(2,426,593)	(6,636,881)	(2,311,491)	(2,618,911)	(2,281,393)	(8,916,203)
EBITDA	1,561,156	2,776,068	(2,462,226)	(597,021)	193,077	3,070,117	(1,965,465)	(2,562,482)	(1,751,406)	1,318,712	(1,527,890)	(4,088,302)
Patient Cash Collected	23,134,663	146,670,325	20,142,893	141,025,765	20,385,383	167,055,709	18,367,715	159,393,480	20,431,608	187,487,316	19,949,375	179,342,855
Cash and Cash Equivalents	28,211,027	28,211,027	19,973,015	19,973,015	22,985,041	22,985,041	20,561,276	20,561,276	25,158,418	25,158,418	22,002,562	22,002,562
Net Working Capital	28,980,645	28,980,645	23,325,453	23,325,453	27,927,063	27,927,063	21,016,187	21,016,187	23,852,861	23,852,861	16,603,661	16,603,661
Unrestricted Assets	39,376,425	39,376,425	25,529,619	25,529,619	38,925,347	38,925,347	23,087,146	23,087,146	36,343,160	36,343,160	20,585,575	20,585,575
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Total GWHN

	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15
A. Operating Performance								
Operating Margin	-4.04%	-3.03%	-20.71%	-6.77%	-6.81%	-3.31%	-14.10%	-7.39%
Non-Operating Margin	-3.17%	-1.80%	-19.90%	-5.81%	-5.61%	-2.12%	-13.35%	-6.45%
Total Margin	-3.72%	-1.62%	-19.53%	-5.97%	-4.63%	-1.88%	-15.30%	-6.77%
Bad Debt as % Gross Revenue	-2.80%	0.16%	1.02%	0.39%	0.79%	0.21%	0.85%	0.43%
B. Liquidity								
Current Ratio	1.68	1.68	0.97	0.97	1.79	1.79	1.03	1.03
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69
C. Leverage and Capital Structure								
Long-term Debt to Equity	0.7431	0.7431	1.5119	1.5119	0.7707	0.7707	1.8978	1.8978
Long-term Debt to Capitalization	0.4263	0.4263	0.6019	0.6019	0.4353	0.4353	0.6549	0.6549
Unrestricted Cash to Debt	1.0410	1.0410	0.1171	0.1171	0.8984	0.8984	0.1166	0.1166
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31
Equity Financing Ratio	2.38	2.38	5.16	5.16	2.40	2.40	6.56	6.56
D. Additional Statistics								
Income from Operations	(178,926)	1,025,260	(3,486,774)	(7,575,080)	(705,922)	402,465	(2,119,606)	(9,694,688)
Revenue Over/(Under) Expense	(868,438)	(3,603,719)	(3,946,434)	(12,862,636)	(1,002,893)	(4,581,472)	(3,064,172)	(15,926,812)
EBITDA	(178,926)	1,025,260	(3,486,774)	(7,575,080)	(705,922)	402,465	(2,119,606)	(9,694,688)
Patient Cash Collected	20,638,288	208,125,604	21,041,111	200,383,967	19,923,196	228,048,799	19,137,425	219,521,392
Cash and Cash Equivalents	28,151,297	28,151,297	3,010,785	3,010,785	24,214,495	24,214,495	2,978,798	2,978,798
Net Working Capital	23,732,718	23,732,718	(1,022,164)	(1,022,164)	25,115,685	25,115,685	1,012,991	1,012,991
Unrestricted Assets	35,190,459	35,190,459	16,415,945	16,415,945	33,840,369	33,840,369	13,002,038	13,002,038
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

EXHIBIT Q51-1

IRS TAX FORM 990 FILED BY GWHN FOR TAX YEAR 2014

MARCUM
ACCOUNTANTS ▲ ADVISORS

AUGUST 12, 2015

BARBARA HALLINAN
THE WATERBURY HOSPITAL
64 ROBBINS STREET
WATERBURY, CT 06708

DEAR BARBARA:

ENCLOSED ARE THE ORGANIZATION'S 2013 EXEMPT ORGANIZATION RETURNS. THE STATE EXEMPT ORGANIZATION RETURN IS ALSO ENCLOSED. THESE SHOULD BE SIGNED, DATED, AND MAILED, AS INDICATED.

SPECIFIC FILING INSTRUCTIONS ARE AS FOLLOWS.

FORM 990 RETURN:

THIS RETURN HAS QUALIFIED FOR ELECTRONIC FILING. AFTER YOU HAVE REVIEWED THE RETURN FOR COMPLETENESS AND ACCURACY, PLEASE SIGN, DATE AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL TRANSMIT THE RETURN ELECTRONICALLY TO THE IRS AND NO FURTHER ACTION IS REQUIRED. RETURN FORM 8879-EO TO US BY AUGUST 17, 2015.

FORM 990-T RETURN:

NO AMOUNT IS DUE ON FORM 990-T.

PLEASE SIGN AND MAIL ON OR BEFORE AUGUST 17, 2015.

MAIL TO - DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE CENTER
OGDEN, UT 84201-0027

CONNECTICUT FORM CT-990T RETURN:

MAIL TO - DEPARTMENT OF REVENUE SERVICES
STATE OF CONNECTICUT
PO BOX 5014
HARTFORD, CT 06102-5014

PLEASE SIGN AND MAIL FORM CT-990T ON OR BEFORE AUGUST 17, 2015.

NO PAYMENT IS REQUIRED.

WE RECOMMEND THAT YOU USE CERTIFIED MAIL WITH POST MARKED RECEIPT FOR PROOF OF TIMELY FILING.

COPIES OF ALL THE RETURNS ARE ENCLOSED FOR YOUR FILES. WE SUGGEST THAT YOU RETAIN THESE COPIES INDEFINITELY.

VERY TRULY YOURS,

DOUGLAS FARRINGTON
MARCUM LLP

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2013, or fiscal year beginning OCT 1 , 2013, and ending SEP 30 ,20 14

▶ **Do not send to the IRS. Keep for your records.**

▶ **Information about Form 8879-EO and its instructions is at** *www.irs.gov/form8879eo*

OMB No. 1545-1878

2013

Name of exempt organization

THE WATERBURY HOSPITAL

Employer identification number

06-0665979

Name and title of officer

DARLENE STROMSTAD
PRESIDENT/TREASURER

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a Form 990 check here ▶ [X]	**b Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	234,229,162.
2a Form 990-EZ check here ▶ [ ]	**b Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a Form 1120-POL check here ▶ [ ]	**b Total tax** (Form 1120-POL, line 22)	**3b**	
4a Form 990-PF check here ▶ [ ]	**b Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a Form 8868 check here ▶ [ ]	**b Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2013 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize MARCUM LLP to enter my PIN 65979

ERO firm name

Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 06411606103

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2013 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ **Do not enter Social Security numbers on this form as it may be made public.**

▶ **Information about Form 990 and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning OCT 1, 2013 **and ending** SEP 30, 2014

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
THE WATERBURY HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) — Room/suite
64 ROBBINS STREET

City or town, state or province, country, and ZIP or foreign postal code
WATERBURY, CT 06708

F Name and address of principal officer: DARLENE STROMSTAD
SAME AS C ABOVE

D Employer identification number
06-0665979

E Telephone number
(203)573-6000

G Gross receipts $ 242,115,744.

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.WATERBURYHOSPITAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1951 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: WATERBURY HOSPITAL'S MISSION IS TO PROVIDE COMPASSIONATE HIGH QUALITY HEALTH CARE SERVICES THROUGH A

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3 Number of voting members of the governing body (Part VI, line 1a)	3	15
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	10
5 Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	1842
6 Total number of volunteers (estimate if necessary)	6	81
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	561,769.
b Net unrelated business taxable income from Form 990-T, line 34	7b	-47,028.

Revenue

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	5,113,352.	5,854,966.
9 Program service revenue (Part VIII, line 2g)	224,908,774.	218,850,300.
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	3,022,281.	3,485,660.
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	6,628,390.	6,038,236.
12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	239,672,797.	234,229,162.

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	119,976,501.	117,637,949.
16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 423,137.		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	115,353,231.	114,190,591.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	235,329,732.	231,828,540.
19 Revenue less expenses. Subtract line 18 from line 12	4,343,065.	2,400,622.

Net Assets or Fund Balances

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	170,955,068.	172,168,042.
21 Total liabilities (Part X, line 26)	84,816,366.	91,192,245.
22 Net assets or fund balances. Subtract line 21 from line 20	86,138,702.	80,975,797.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ DARLENE STROMSTAD, PRESIDENT/TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
DOUGLAS FARRINGTON			☐	P00370668

Firm's name ▶ MARCUM LLP — Firm's EIN ▶ 11-1986323

Firm's address ▶ CITY PLACE II 185 ASYLUM STREET
HARTFORD, CT 06103 — Phone no. 860-760-0600

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
WATERBURY HOSPITAL'S MISSION IS TO PROVIDE COMPASSIONATE HIGH QUALITY HEALTH CARE SERVICES THROUGH A FAMILY OF PROFESSIONALS AND SERVICES.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 192,231,293. including grants of $) (Revenue $ 224,304,746.)
STATEMENT OF PURPOSE

AS A NOT-FOR-PROFIT COMMUNITY HOSPITAL, WATERBURY HOSPITAL PROVIDES QUALITY HEALTH CARE TO ALL AREA INDIVIDUALS, REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, AGE, HANDICAP OR ABILITY TO PAY. HOWEVER, REIMBURSEMENT FOR SERVICES IS CRITICAL TO THE HOSPITAL'S STABILITY AND LONG-TERM OPERATION.

SEE SCHEDULE O FOR CONTINUATION

4b (Code:) (Expenses $ including grants of $) (Revenue $)

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 192,231,293.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a	X	
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	325		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1842		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a		X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year 1a	15		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent 1b	10		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? 2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? 3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? 4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets? 5			X
6	Did the organization have members or stockholders? 6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? 7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? 7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body? 8a		X	
b	Each committee with authority to act on behalf of the governing body? 8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O* 9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates? 10a			X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? 10b			
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? 11a		X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13* 12a		X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? 12b		X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done* 12c		X	
13	Did the organization have a written whistleblower policy? 13		X	
14	Did the organization have a written document retention and destruction policy? 14		X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official 15a		X	
b	Other officers or key employees of the organization 15b		X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? 16a		X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? 16b			X

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ NONE

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☒ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

SCOTT BOWMAN - 203-573-7333

64 ROBBINS STREET, WATERBURY, CT 06708

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DARLENE STROMSTAD	40.00									
PRESIDENT/TREASURER	26.00	X		X				576,786.	0.	93,364.
(2) CARL D. CONTADINI	0.30									
CHAIRMAN	0.30	X		X				0.	0.	0.
(3) JOHN A. KELLY, JR.	0.30									
VICE CHAIRMAIN	0.30	X		X				0.	0.	0.
(4) ANDREW K. SKIPP	0.20									
SECRETARY	0.20	X		X				0.	0.	0.
(5) CARL B. SHERTER, MD	7.00									
DIRECTOR	0.30	X						18,750.	0.	0.
(6) RON J. D'ANDREA, MD	0.20									
DIRECTOR	0.20	X						0.	0.	0.
(7) DR. HENRY BORKOWSKI	40.30									
DIRECTOR / CAGW - CARDIOLOGIST	0.30	X						750,082.	0.	37,460.
(8) JAMES H. GATLING, PH.D	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(9) PATRICIA MCKINLEY	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(10) JOHN A. MICHAELS	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(11) DAVID J. PIZZUTO, MD	20.00									
DIRECTOR / VP MEDICAL SERVICES	7.00	X		X				173,784.	0.	8,431.
(12) WILLIAM J. PIZZUTO, PH.D	0.90									
DIRECTOR	0.90	X						0.	0.	0.
(13) DR. NEIL PETERSEN	7.00									
CHIEF OF STAFF	0.30	X						56,250.	0.	0.
(14) FRANK SHERER	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(15) SUNDAE BLACK	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(16) SANDRA A. IADAROLA	40.00									
CHIEF NURSING OFFICER	2.10			X				250,887.	0.	16,691.
(17) DIANE M. WOOLLEY	40.00									
VP HUMAN RESOURCES	5.00			X				234,355.	0.	24,691.

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) MICHAEL J. CEMENO	40.00									
CHIEF INFORMATION OFFICER	7.00			X				354,243.	0.	22,504.
(19) THOMAS M. BURKE	40.00									
VICE PRESIDENT OPERATIONS	1.80			X				188,048.	0.	17,043.
(20) EDWARD ROMERO	40.00									
CHIEF FINANCIAL OFFICER	8.00			X				111,903.	0.	34,171.
(21) EHSAN ANSARI	40.00									
CAGW - CARDIOLOGIST						X		876,277.	0.	41,847.
(22) KEVIN KETT	40.00									
CAGW - CARDIOLOGIST						X		861,837.	0.	41,847.
(23) JOSEPH MORLEY	40.00									
CAGW - CARDIOLOGIST						X		884,876.	0.	41,847.
(24) MARK RUGGIERO	40.00									
CAGW - CARDIOLOGIST						X		763,998.	0.	41,370.
(25) STEPHEN WIDMAN	40.00									
CAGW - CARDIOLOGIST						X		783,391.	0.	41,847.
1b Sub-total ▶								6,885,467.	0.	463,113.
c Total from continuation sheets to Part VII, Section A ▶								0.	0.	0.
d Total (add lines 1b and 1c) ▶								6,885,467.	0.	463,113.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 140

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
SODEXO, INC. AND AFFILIATES P.O. BOX 360170, PITTSBURGH, PA 15251-6170	DIETARY, BUILDING SVCS, TRANSPORT	4,455,266.
YALE UNIVERSITY P.O. BOX 208087, NEW HAVEN, CT 06520-8087	CLINICAL SERVICES	3,311,580.
CROTHALL HEALTHCARE 1500 LIBERTY RIDGE DRIVE, WAYNE, PA 19087	BUILDING SVCS, TRANSPORT SVCS	2,974,633.
MORRISON HEALTHCARE, 5801 PEACHTREE DUNWOODY RD, ATLANTA, GA 30342	DIETARY SERVICES	2,212,473.
CERNER CORPORATION, 2800 ROCKCREEK PARKWAY, KANSAS CITY, MO 64117	INFORMATION TECHNOLOGY	1,663,762.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 62

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e	4,369,303.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,485,663.				
	g Noncash contributions included in lines 1a-1f: $ 10,000.						
	h **Total.** Add lines 1a-1f ▶			5,854,966.			
Program Service Revenue		**Business Code**					
	2a NET PATIENT SERVICE REVENUE	624100		211,757,869.	211,757,869.		
	b CAW - NET PATIENT SERVICE REVENUE	621110		6,530,662.	6,530,662.		
	c LAB SERVICE REVENUE	621500		361,940.		361,940.	
	d IMAGE REPAIRS & MAINTENANCE	541900		199,829.		199,829.	
	e						
	f All other program service revenue						
	g **Total.** Add lines 2a-2f ▶			218,850,300.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶			2,933,557.			2,933,557.
	4 Income from investment of tax-exempt bond proceeds ▶						
	5 Royalties ▶						
		(i) Real	(ii) Personal				
	6a Gross rents	443,052.					
	b Less: rental expenses	0.					
	c Rental income or (loss)	443,052.					
	d Net rental income or (loss) ▶			443,052.			443,052.
		(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory	8,288,813.					
	b Less: cost or other basis and sales expenses	7,725,938.	10,772.				
	c Gain or (loss)	562,875.	-10,772.				
	d Net gain or (loss) ▶			552,103.			552,103.
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a	275,775.				
	b Less: direct expenses	b	149,872.				
	c Net income or (loss) from fundraising events ▶			125,903.			125,903.
	9a Gross income from gaming activities. See Part IV, line 19	a					
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities ▶						
	10a Gross sales of inventory, less returns and allowances	a					
	b Less: cost of goods sold	b					
	c Net income or (loss) from sales of inventory ▶						
	Miscellaneous Revenue	**Business Code**					
	11a CAW - OTHER INCOME	621110		1,762,014.	1,762,014.		
	b PARTNERSHIPS	900099		1,736,142.	1,736,142.		
	c MEANINGFUL USE INCOME	900099		1,507,510.	1,507,510.		
	d All other revenue	900099		463,615.	448,780.		14,835.
	e **Total.** Add lines 11a-11d ▶			5,469,281.			
	12 **Total revenue.** See instructions. ▶			234,229,162.	223,742,977.	561,769.	4,069,450.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	3,170,788.	659,105.	2,511,683.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	89,903,497.	83,785,315.	5,955,707.	162,475.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	4,737,029.	4,330,381.	397,864.	8,784.
9 Other employee benefits	13,143,592.	11,993,207.	1,125,748.	24,637.
10 Payroll taxes	6,683,043.	6,057,775.	612,986.	12,282.
11 Fees for services (non-employees):				
a Management				
b Legal	1,686,113.	136,931.	1,549,182.	
c Accounting	228,878.		228,878.	
d Lobbying	108,506.		108,506.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	407,116.		407,116.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	50,206,311.	38,807,958.	11,396,754.	1,599.
12 Advertising and promotion	701,405.	32,349.	669,056.	
13 Office expenses	10,282,481.	8,261,831.	1,997,490.	23,160.
14 Information technology				
15 Royalties				
16 Occupancy	4,793,989.	1,271,485.	3,522,504.	
17 Travel	99,088.	49,590.	46,621.	2,877.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	98,590.	91,816.	6,774.	
20 Interest	1,352,572.		1,352,572.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	6,998,818.		6,998,818.	
23 Insurance	6,945,049.	6,945,049.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL/SURGICAL SUPPLI	25,414,234.	25,414,234.		
b BAD DEBT	3,826,557.	3,826,557.		
c FOOD	372,699.	335,118.	37,581.	
d DUES AND SUBSCRIPTIONS	310,735.	106,101.	204,040.	594.
e All other expenses	357,450.	126,491.	44,230.	186,729.
25 **Total functional expenses.** Add lines 1 through 24e	231,828,540.	192,231,293.	39,174,110.	423,137.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	554,115.	1	3,350,462.
	2	Savings and temporary cash investments	24,214,034.	2	25,198,842.
	3	Pledges and grants receivable, net	3,198,969.	3	3,751,232.
	4	Accounts receivable, net	24,894,454.	4	26,880,306.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	3,418,629.	8	3,697,723.
	9	Prepaid expenses and deferred charges	1,414,532.	9	1,627,875.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 268,299,225.			
	b	Less: accumulated depreciation — 10b: 236,745,837.	37,464,222.	10c	31,553,388.
	11	Investments - publicly traded securities	12,387,068.	11	12,842,247.
	12	Investments - other securities. See Part IV, line 11	60,522,477.	12	60,513,519.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets	1,813,567.	14	1,813,567.
	15	Other assets. See Part IV, line 11	1,073,001.	15	938,881.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	170,955,068.	16	172,168,042.
Liabilities	17	Accounts payable and accrued expenses	26,958,532.	17	29,601,547.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	24,755,656.	20	24,283,520.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	33,102,178.	25	37,307,178.
	26	**Total liabilities.** Add lines 17 through 25	84,816,366.	26	91,192,245.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	29,976,833.	27	23,336,473.
	28	Temporarily restricted net assets	8,409,794.	28	8,729,527.
	29	Permanently restricted net assets	47,752,075.	29	48,909,797.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	86,138,702.	33	80,975,797.
	34	Total liabilities and net assets/fund balances	170,955,068.	34	172,168,042.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	234,229,162.
2	Total expenses (must equal Part IX, column (A), line 25)	2	231,828,540.
3	Revenue less expenses. Subtract line 2 from line 1	3	2,400,622.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	86,138,702.
5	Net unrealized gains (losses) on investments	5	118,716.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-7,682,243.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	80,975,797.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII X

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE WATERBURY HOSPITAL

Employer identification number

06-0665979

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ..... ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	**11g(i)**	
(ii)	A family member of a person described in (i) above?	**11g(ii)**	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	**11g(iii)**	

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
Total									

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ..... ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) ..... 14 %

15 Public support percentage from 2012 Schedule A, Part II, line 14 ..... 15 %

16a **33 1/3% support test - 2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ..... ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2012** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2013.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at www.irs.gov/form990 .

OMB No. 1545-0047

2013

Name of the organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	☒ 501(c)(3) (enter number) organization
	☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	☐ 527 political organization
Form 990-PF	☐ 501(c)(3) exempt private foundation
	☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation
	☐ 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

☒ For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

☐ For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of $5,000 or more during the year ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	CARMODY, TORRANCE, SANDAK & HENNESSEY LLP 50 LEAVENWORTH STREET WATERBURY, CT 06721	$ 40,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2	CLY-DEL MANUFACTURING CO. 151 SHARON ROAD WATERBURY, CT 06721	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3	CONNECTICARE, INC. 175 SCOTT SWAMP RD. FARMINGTON, CT 06034-4050	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4	ION BANK FOUNDATION 251 CHURCH STREET NAUGATUCK, CT 06770	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5	ONYX JEWELERS 683 MAIN STREET WATERTOWN, CT 06795	$ 10,000.	Person [ ] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
6	THE HAROLD LEEVER REGIONAL CANCER CENTER 1075 CHASE PARKWAY WATERBURY, CT 06708	$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	WATERBURY HOSPITAL AUXILIARY, INC. 64 ROBBINS STREET WATERBURY, CT 06708	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8	COCA-COLA REFRESHMENTS 80 RADO DRIVE NAUGATUCK, CT 06770	$ 11,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
9	CROTHALL HEALTHCARE 1500 LIBERTY RIDGE DRIVE WAYNE, PA 19087-5583	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
10	DIAGOSTIC RADIOLOGY ASSOCIATES, INC. 134 GRANDVIEW AVENUE WATERBURY, CT 06708	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
11	HARTNETT FOUNDATION 385 SOUTH STREET MIDDLEBURY, CT 06762-3523	$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
12	ESTATE OF JOSEPH KEZELEVICH ONE WEST FOURTH STREET WINSTON-SALEM, NC 27101	$ 22,739.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	ESTATE OF MADELYN QUEOR C/O FARRELL, GEENTY, SHEELEY, BOCCALATTE & GUARINO PC, 141 BROAD ST. MIDDLETOWN, CT 06457	$ 107,157.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
14	TRUST OF DOROTHEA C. RICH 574 HERITAGE ROAD SOUTHBURY, CT 06488	$ 40,460.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
15	ROLLER BEARING COMPANY OF AMERICA, INC. 102 WILLENBROCK ROAD OXFORD, CT 06478	$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
16	RONALD MCDONALD HOUSE CHARITIES OF CT & WESTERN MA CHAPTER 501 GEORGE STREET NEW HAVEN, CT 06511	$ 12,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
17	ESTATE OF FERN VERRIKER C/O US TRUST - BANK OF AMERICA 200 GLASTONBURY BLVD. - 2ND FLOOR GLASTONBURY, CT 06033	$ 193,573.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
18	THE DAVID, HELEN & MARIAN WOODWARD FUND P.O. BOX 817 WATERTOWN, CT 06795	$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	HYGRADE BUSINESS GROUP, INC. 1525 HAMILTON AVENUE WATERBURY, CT 06706	$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
5	JEWELRY	$ 10,000.	12/04/13
		$	
		$	
		$	
		$	
		$	
		$	

Name of organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

Part III *Exclusively* **religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **See separate instructions.** ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures ▶ $
3 Volunteer hours

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?	X		
d Mailings to members, legislators, or the public?	X		
e Publications, or published or broadcast statements?	X		
f Grants to other organizations for lobbying purposes?	X		60,000.
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?	X		
i Other activities?	X		48,506.
j Total. Add lines 1c through 1i			108,506.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

		Yes	No
1 Were substantially all (90% or more) dues received nondeductible by members?	1		
2 Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3 Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1 Dues, assessments and similar amounts from members	1	
2 Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a Current year	2a	
b Carryover from last year	2b	
c Total	2c	
3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5 Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

A PORTION OF THE CT HOSPITAL ASSOCIATION AND AMERICAN HOSPITAL ASSOCIATION FEES THAT ARE PAID BY THE WATERBURY HOSPITAL IS FOR LOBBYING ACTIVITIES. THE WATERBURY HOSPITAL ALSO PAYS ROY AND LEROY LLC FOR LOBBYING SERVICES TOTALING $60,000.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).
- ☐ Preservation of land for public use (e.g., recreation or education)
- ☐ Protection of natural habitat
- ☐ Preservation of open space
- ☐ Preservation of an historically important land area
- ☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	58,391,891.	54,791,385.	48,442,875.	51,457,624.	49,308,865.
b Contributions					20.
c Net investment earnings, gains, and losses	2,214,558.	4,160,381.	6,884,672.	-2,784,813.	2,729,359.
d Grants or scholarships					
e Other expenditures for facilities and programs	773,967.	559,875.	536,162.	229,936.	580,620.
f Administrative expenses					
g End of year balance	59,832,482.	58,391,891.	54,791,385.	48,442,875.	51,457,624.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 5.54 %
b Permanent endowment ▶ 81.75 %
c Temporarily restricted endowment ▶ 12.71 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)	X	
(ii) related organizations	3a(ii)		X
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		287,549.		287,549.
b Buildings		86,691,215.	71,666,585.	15,024,630.
c Leasehold improvements		654,276.	487,682.	166,594.
d Equipment		177,982,606.	162,263,411.	15,719,195.
e Other		2,683,579.	2,328,159.	355,420.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				31,553,388.

Schedule D (Form 990) 2013

332052
09-25-13

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD IN TRUST BY		
(B) OTHERS	46,117,761.	END-OF-YEAR MARKET VALUE
(C) GREATER WATERBURY IMAGING		
(D) CENTER	3,790,798.	END-OF-YEAR MARKET VALUE
(E) ACCESS REHAB CENTERS	4,927,550.	END-OF-YEAR MARKET VALUE
(F) IMAGING PARTNERS	434,844.	END-OF-YEAR MARKET VALUE
(G) ALLIANCE MEDICAL GROUP	5,242,566.	END-OF-YEAR MARKET VALUE
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	60,513,519.	

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	

Part X Other Liabilities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) LIABILITIES OF CONSOLIDATED	
(3) AFFILIATES	2,048,387.
(4) RESERVE FOR WORKER'S	
(5) COMP/MALPRACTICE LIAB. LOSS	13,249,306.
(6) NONCONTROLLING INTEREST	2,716,294.
(7) DEFERRED LIAB. ON GIFT ANNUITY	108,707.
(8) ASSET RETIREMENT OBLIGATION	2,801,923.
(9) CAPITAL LEASE LIABILITY	820,591.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	37,307,178.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	262,082,503.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a	118,716.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	29,940,684.		
e	Add lines **2a** through **2d**			2e	30,059,400.
3	Subtract line **2e** from line **1**			3	232,023,103.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	407,116.		
b	Other (Describe in Part XIII.)	4b	1,798,943.		
c	Add lines **4a** and **4b**			4c	2,206,059.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	234,229,162.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	266,851,958.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d	35,430,534.		
e	Add lines **2a** through **2d**			2e	35,430,534.
3	Subtract line **2e** from line **1**			3	231,421,424.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	407,116.		
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	407,116.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	231,828,540.

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4:

THE ENDOWMENT FUNDS ARE USED FOR FREE CARE AND GENERAL HOSPITAL OPERATIONS.

PART X, LINE 2:

THE HOSPITAL IS A NOT-FOR-PROFIT CORPORATION AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND IS EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE. THE HOSPITAL IS ALSO EXEMPT FROM STATE INCOME TAXES. ACCESS, GWIC, CAGW, AND IMAGING PARTNERS LLC ARE PARTNERSHIPS. FOR TAX PURPOSES, THESE PARTNERSHIP ARE PASS-THROUGH ENTITIES. TAXATION DOES NOT OCCUR AT THE PARTNERSHIP LEVEL. ACCORDINGLY, NO PROVISION FOR TAXES IS INCLUDED. AMG IS TAX EXEMPT

Part XIII Supplemental Information *(continued)*

UNDER SECTION 501(C)(3) OF THE CODE.

MANAGEMENT HAS ANALYZED THE TAX POSITIONS TAKEN AND HAS CONCLUDED THAT AS OF SEPTEMBER 30, 2014, THERE ARE NO UNCERTAIN TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN IN THAT WOULD REQUIRE RECOGNITION OF A LIABILITY (OR ASSET) OR DISCLOSURE IN THE FINANCIAL STATEMENTS. THE HOSPITAL IS SUBJECT TO ROUTINE AUDITS BY TAXING JURISDICTIONS; HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS IN PROGRESS. MANAGEMENT BELIEVES THE HOSPITAL IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS PRIOR TO 2011.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

INCOME FROM CONSOLIDATED AFFILIATES	29,790,812.
FUNDRAISING EXPENSE	149,872.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	29,940,684.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

INVESTMENT INCOME FROM PARTNERSHIP	1,736,142.
WATERBURY GASTROENTEROLOGY INCOME	62,801.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	1,798,943.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

EXPENSE OF CONSOLIDATED AFFILIATES	35,280,662.
FUNDRAISING EXPENSE	149,872.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	35,430,534.

Part XIII Supplemental Information *(continued)*

Part X Other Liabilities. See Form 990, Part X, line 25.

(a) Description of liability	(b) Amount
ACCRUED PENSION LIABILITY	6,860,268.
DEFERRED LIAB. ON SERP	330,148.
SWAP RATE LIABILITY	1,512,596.
DUE TO AFFILIATES	2,386,118.
DUE TO THIRD-PARTY REIMBURSEMENT AGENCIES	4,171,981.
SODEXO LIABILITY	300,859.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule G (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a ☐ Mail solicitations
b ☐ Internet and email solicitations
c ☐ Phone solicitations
d ☐ In-person solicitations
e ☐ Solicitation of non-government grants
f ☐ Solicitation of government grants
g ☐ Special fundraising events

2 a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Total ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Part II **Fundraising Events.** Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than $15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than $5,000.

		(a) Event #1 GALA (event type)	(b) Event #2 GOLF TOURNAMENT (event type)	(c) Other events 1 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	142,035.	94,080.	39,660.	275,775.
	2 Less: Contributions				
	3 Gross income (line 1 minus line 2)	142,035.	94,080.	39,660.	275,775.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes		5,940.		5,940.
	6 Rent/facility costs	34,350.	20,379.	14,550.	69,279.
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	54,732.	4,812.	15,109.	74,653.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				149,872.
	11 Net income summary. Subtract line 3, column (d) ▶				125,903.

Part III **Gaming.** Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				
	8 Net gaming income summary. Subtract line 7 from line 1, column (d) ▶				

9 Enter the state(s) in which the organization operates gaming activities: _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____ .

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

Part IV **Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990 .

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other _____ %	3b	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			1378274.	559,653.	818,621.	.36%
b Medicaid (from Worksheet 3, column a)		47,294	44947471.	37027473.	7919998.	3.47%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		47,294	46325745.	37587126.	8738619.	3.83%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		38,050			9127921.	4.00%
f Health professions education (from Worksheet 5)		3,300	17393811.	8733484.	8660327.	3.80%
g Subsidized health services (from Worksheet 6)		2,421	10750684.	10162296.	588,388.	.26%
h Research (from Worksheet 7)		17			5,580.	.00%
i Cash and in-kind contributions for community benefit (from Worksheet 8)		112,275			108,982.	.05%
j **Total.** Other Benefits		156,063	28144495.	18895780.	18491198.	8.11%
k **Total.** Add lines 7d and 7j		203,357	74470240.	56482906.	27229817.	11.94%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support		11,969	13,163.		13,163.	.01%
4	Environmental improvements						
5	Leadership development and training for community members		414	326,775.	131,908.	194,867.	.09%
6	Coalition building		430	50,405.		50,405.	.02%
7	Community health improvement advocacy						
8	Workforce development						
9	Other			45,672.	29,936.	15,736.	.01%
10	**Total**		12,813	436,015.	161,844.	274,171.	.13%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	871,605.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	0.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	70,728,737.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	78,479,664.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-7,750,927.		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other				

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a		X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 THE WATERBURY HOSPITAL 64 ROBBINS STREET WATERBURY, CT 06708	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group THE WATERBURY HOSPITAL

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url):			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[ ] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide plan			
d	[X] Participation in the execution of a community-wide plan			
e	[ ] Inclusion of a community benefit section in operational plans			
f	[ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	X	
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? **$**			

Part V Facility Information *(continued)* THE WATERBURY HOSPITAL

		Yes	No
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %			
If "No," explain in Section C the criteria the hospital facility used.			
11 Used FPG to determine eligibility for providing *discounted* care?	11	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
If "No," explain in Section C the criteria the hospital facility used.			
12 Explained the basis for calculating amounts charged to patients?	12	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a [X] Income level			
b [X] Asset level			
c [ ] Medical indigency			
d [ ] Insurance status			
e [ ] Uninsured discount			
f [ ] Medicaid/Medicare			
g [ ] State regulation			
h [ ] Residency			
i [ ] Other (describe in Section C)			
13 Explained the method for applying for financial assistance?	13	X	
14 Included measures to publicize the policy within the community served by the hospital facility?	14	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a [X] The policy was posted on the hospital facility's website			
b [X] The policy was attached to billing invoices			
c [X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d [X] The policy was posted in the hospital facility's admissions offices			
e [ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f [X] The policy was available on request			
g [ ] Other (describe in Section C)			
Billing and Collections			
15 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Section C)			
17 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a [ ] Reporting to credit agency			
b [ ] Lawsuits			
c [ ] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Section C)			

Part V Facility Information *(continued)* THE WATERBURY HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** [X] Notified individuals of the financial assistance policy on admission
- **b** [X] Notified individuals of the financial assistance policy prior to discharge
- **c** [X] Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** [X] Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** [ ] Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- **a** [ ] The hospital facility did not provide care for any emergency medical conditions
- **b** [ ] The hospital facility's policy was not in writing
- **c** [ ] The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** [ ] Other (describe in Section C)

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** [ ] The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** [ ] The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** [ ] The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** [X] Other (describe in Section C)

21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	21		X
22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	22		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

THE WATERBURY HOSPITAL:

PART V, SECTION B, LINE 3: COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION (2013 - 2016)

IN 2012, SEVERAL COMMUNITY ORGANIZATIONS CAME TOGETHER TO CONDUCT A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THESE ORGANIZATIONS FORMED THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (GWHIP). THE INITIAL PARTNERS OF GWHIP INCLUDED WATERBURY HOSPITAL, SAINT MARY'S HOSPITAL, STAYWELL HEALTH CENTER, UNITED WAY OF GREATER WATERBURY, CONNECTICUT COMMUNITY FOUNDATION, AND THE WATERBURY DEPARTMENT OF HEALTH.

THE 2012 CHNA INCLUDED BOTH QUANTITATIVE AND QUALITATIVE DATA COLLECTION. FOR QUANTITATIVE DATA COLLECTION, A HOUSEHOLD TELEPHONE SURVEY WAS CONDUCTED ALONG WITH A KEY INFORMANT ONLINE SURVEY AND A REVIEW OF SECONDARY DATA. FOR QUALITATIVE DATA, GWHIP CONDUCTED FOCUS GROUPS WITH BOTH HEALTHCARE PROVIDERS AND HEALTHCARE CONSUMERS. THE RESEARCH WAS PRESENTED TO A GROUP OF COMMUNITY LEADERS WHO VOTED ON COMMUNITY HEALTH PRIORITIES. WATERBURY HOSPITAL THEN DEVELOPED AN IMPLEMENTATION STRATEGY BASED ON THE COMMUNITY HEALTH PRIORITIES. THE IMPLEMENTATION STRATEGY WAS ADOPTED BY THE WATERBURY HOSPITAL BOARD OF DIRECTORS ON SEPTEMBER 26, 2013.

GWHIP ESTABLISHED A STEERING COMMITTEE TO ADDRESS THE FOUR COMMUNITY HEALTH PRIORITIES: (1) ACCESS TO CARE; (2) MENTAL HEALTH AND SUBSTANCE ABUSE; (3) OBESITY AND CHRONIC DISEASES; AND (4) TOBACCO USE. WATERBURY HOSPITAL LEADERS PARTICIPATE ON THE GWHIP STEERING COMMITTEE WHICH MEETS

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

MONTHLY. OTHER WATERBURY HOSPITAL STAFF MEMBERS PARTICIPATE IN THE FOUR WORK GROUPS WHICH ALSO MEET MONTHLY. THE WORK GROUPS HAVE WORK PLANS, INCLUDING GOALS AND OBJECTIVES FOR THE THREE-YEAR PERIOD FOLLOWING THE INITIAL CHNA.

WATERBURY HOSPITAL IS PRESENTLY ADDRESSING THE IMPLEMENTATION STRATEGY THAT WAS ADOPTED BY THE BOARD ON SEPTEMBER 26, 2013. FOR EXAMPLE REGARDING THE OBESITY PRIORITY, WATERBURY HOSPITAL RECENTLY BEGAN OFFERING A FARMER'S MARKET ON-SITE FOR BOTH STAFF AND COMMUNITY MEMBERS. THE FARMER'S MARKET IS COORDINATED BY BRASS CITY HARVEST, WHICH IS A NON-PROFIT ORGANIZATION AND ITS STAFF MEMBERS ARE ACTIVELY INVOLVED IN GWHIP. WATERBURY HOSPITAL STAFF MEMBERS ARE ALSO INVOLVED IN THE PLANTING OF FRUIT AND VEGETABLE GARDENS ACROSS THE STREET FROM JONATHAN REED ELEMENTARY SCHOOL. STUDENTS AND PARENTS CAN HARVEST THE FRUITS AND VEGETABLES LATER IN THE SUMMER.

THE YOUTH PIPELINE PROGRAM IS ALSO TEACHING STUDENTS ABOUT FOOD AND HEALTHY EATING. THE HOSPITAL DIETICIAN LED A CLASS ON MAKING "EDIBLE ARRANGEMENTS." THE STUDENTS USED PINEAPPLES, STRAWBERRIES, GRAPES, AND BLUEBERRIES IN THIS EXERCISE. STUDENTS ALSO GOT HANDS ON EXPERIENCE PREPARING HEALTHY HOT AND COLD MEALS WHILE WORKING DIRECTLY WITH THE HOSPITAL NUTRITIONIST.

COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLANNING (2016 - 2019)

WATERBURY HOSPITAL HAS STARTED WORKING ON THE NEXT COMMUNITY HEALTH NEEDS

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

ASSESSMENT (CHNA). WATERBURY HOSPITAL WILL WORK WITH GWHIP ONCE AGAIN ON COMPLETING THE CHNA. WATERBURY HOSPITAL HAS CONTRIBUTED FINANCIALLY TOWARD THE CONNECTICUT WELLBEING SURVEY. THE CONNECTICUT WELLBEING SURVEY IS A TELEPHONE SURVEY ADMINISTERED BY DATAHAVEN, WHICH IS A NON-PROFIT ORGANIZATION WITH THE MISSION OF IMPROVING THE QUALITY OF LIFE BY COLLECTING, SHARING AND INTERPRETING PUBLIC DATA FOR EFFECTIVE DECISION MAKING.

DATAHAVEN WAS ACTIVELY INVOLVED IN YALE-NEW HAVEN HOSPITAL'S CHNA IN 2013 WHEN THE FIRST WELLBEING SURVEY WAS CONDUCTED IN THE NEW HAVEN REGION. THE 2015 - 2016 WELLBEING SURVEY WILL COVER THE ENTIRE STATE OF CONNECTICUT. GWHIP, INCLUDING WATERBURY HOSPITAL, CONTRIBUTED FINANCIAL RESOURCES TO DATAHAVEN SO THAT AN ADDITIONAL 1,100 PHONE CALLS WOULD BE MADE TO RESIDENTS IN WATERBURY HOSPITAL'S SERVICE AREA. THE ADDITIONAL PHONE CALLS WILL ALLOW GWHIP MEMBERS TO UNDERSTAND HEALTH AND WELLBEING ISSUES AT THE NEIGHBORHOOD LEVEL.

THE WELLBEING SURVEY QUESTIONS COVER TRADITIONAL HEALTH RELATED TOPICS. FOR EXAMPLE THE PHONE SURVEYOR ASKS "HAVE YOU EVER BEEN TOLD BY A HEALTH CARE PROVIDER THAT YOU HAVE DIABETES?" ANOTHER QUESTION IS "HAVE YOU EVER BEEN TOLD BY A HEALTH CARE PROVIDER THAT YOU HAVE HIGH CHOLESTEROL?" IN ADDITION TO THOSE HEALTH-RELATED QUESTIONS, THE WELLBEING SURVEY ALSO COVERS OTHER INDICATORS AROUND THE SOCIAL DETERMINANTS OF HEALTH. QUESTIONS COVER THE FOLLOWING AREAS: HOUSING, HEALTH, EDUCATION, CIVIC VITALITY, PUBLIC SAFETY AND ENVIRONMENTAL ISSUES.

WHILE THE WELLBEING SURVEY DATA WILL PROVIDE THE MAJORITY OF QUANTITATIVE

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

DATA FOR THE NEXT CHNA, GWHIP WILL ALSO DO A REVIEW OF SECONDARY DATA. WATERBURY HOSPITAL WILL WORK WITH GWHIP, INCLUDING SAINT MARY'S HOSPITAL, ON COLLECTING QUALITATIVE DATA SUCH AS FOCUS GROUP AND KEY INFORMANT INTERVIEWS. BOTH HOSPITALS TOGETHER WILL PRODUCE A CHNA THAT MEETS ALL IRS REQUIREMENTS. WATERBURY HOSPITAL WILL DEVELOP AN IMPLEMENTATION STRATEGY BASED ON THE QUANTITATIVE AND QUALITATIVE DATA COLLECTED. THIS IMPLEMENTATION STRATEGY WILL BE PRESENTED TO THE WATERBURY HOSPITAL BOARD OF DIRECTORS BY SEPTEMBER 30, 2016.

THE WATERBURY HOSPITAL:

PART V, SECTION B, LINE 4: ST. MARY'S HOSPITAL

THE WATERBURY HOSPITAL:

PART V, SECTION B, LINE 20D: ALL PATIENTS ARE CHARGED THE SAME.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 7

Name and address	Type of Facility (describe)
1 CARDIOLOGY ASSOCIATES OF GTR WATERBURY 455 CHASE PARKWAY WATERBURY, CT 06708	MEDICAL OFFICES, DIAGNOSTIC TESTING
2 BLOOD DRAW STATION 134 GRANDVIEW AVENUE WATERBURY, CT 06708	BLOOD DRAWING FACILITY
3 BLOOD DRAW STATION 1625 STRAITS TURNPIKE, SUITE 304 MIDDLEBURY, CT 06762	BLOOD DRAWING FACILITY/X-RAYS
4 BLOOD DRAW STATION 22 OLD WATERBURY ROAD, SUITE 201 SOUTHBURY, CT 06488	BLOOD DRAWING FACILITY
5 BLOOD DRAW STATION 130 SOUTH MAIN STREET THOMASTON, CT 06787	BLOOD DRAWING FACILITY
6 BLOOD DRAW STATION 51 DEPOT STREET, SUITE 212 WATERTOWN, CT 06795	BLOOD DRAWING FACILITY
7 BLOOD DRAW STATION 305 CHURCH STREET, SUITE 16 NAUGATUCK, CT 06770	BLOOD DRAWING FACILITY

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 3C:

N/A

PART I, LINE 6A:

YES, WATERBURY HOSPITAL DID PREPARE A COMMUNITY BENEFIT REPORT.

PART II, COMMUNITY BUILDING ACTIVITIES:

AS A LEADER IN THE DELIVERY OF HEALTHCARE SERVICES IN THE GREATER WATERBURY AREA, WATERBURY HOSPITAL (WH) IS COMMITTED TO STRENGTHENING THE WELFARE AND AWARENESS OF THE CITIZENS WITHIN ITS COMMUNITY. FROM STRENGTHENING THE CAREER PATHS OF WATERBURY AREA YOUTH; TO SUPPORTING THE UNINSURED AND UNDERINSURED THROUGH THE WATERBURY HEALTH ACCESS PROGRAM AND; PROVIDING TRANSPORT TO AND FROM MEDICAL APPOINTMENTS; WATERBURY HOSPITAL IS REMOVING THE BARRIERS TO QUALITY HEALTH CARE FOR ALL AND REMAINS FIRM IN ITS COMMITMENT TO A HEALTHIER, STRONGER, AND MORE PRODUCTIVE COMMUNITY.

Part VI Supplemental Information *(Continuation)*

KEY PROGRAMS:

YOUTH PIPELINE INITIATIVES: THE WATERBURY HOSPITAL YOUTH PIPELINE INITIATIVES WERE ESTABLISHED IN 2001 AS A PARTNERSHIP BETWEEN WATERBURY HOSPITAL AND WATERBURY PUBLIC SCHOOLS. THE MISSION OF THE PROGRAM IS TO CLOSE THE ACHIEVEMENT GAP FOR MINORITY AND ECONOMICALLY DISADVANTAGED STUDENTS IN WATERBURY SO THEY CAN MATRICULATE AND COMPETE NATIONALLY FOR PLACEMENT IN POST-SECONDARY EDUCATION PROGRAMS IN PREPARATION FOR HEALTH CAREERS. WATERBURY HOSPITAL IS COMMITTED TO ENHANCING AND ENRICHING THE ACADEMIC OPPORTUNITIES AND PERSONAL JOURNEYS OF OUR YOUTH, WHO ARE THE EMERGING WORKFORCE OF TOMORROW. TO THIS END, DURING 2014, WATERBURY HOSPITAL PROVIDED 129 STUDENTS AND PARENTS IN GREATER WATERBURY WITH UNIQUE EDUCATIONAL PROGRAMS THAT WILL ENHANCE THE OVERALL WELFARE OF OUR COMMUNITY.

THE WH YOUTH PIPELINE INITIATIVES HAD SIX FOCUS AREAS DURING FY 2014, INCLUDING:

- PARENT LEADERSHIP TRAINING INSTITUTE (PLTI) - IN 2014, SIX INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED WATERBURY'S PLTI, A 20-WEEK CURRICULUM TEACHING LEADERSHIP AND ADVOCACY SKILLS, AS WELL AS INDIVIDUAL COMMUNITY PROJECT PLANNING. PLTI'S CORE MISSION IS TO IMPART LEADERSHIP AND ADVOCACY SKILLS TO PARENTS WHILE SIMULTANEOUSLY EDUCATING THEM ABOUT VOLUNTEERISM, CIVIC LIFE, AND THE PROCESS BY WHICH STATE AND LOCAL GOVERNMENTS ENACT AND CHANGE LAWS.

- PARENTS SUPPORTING EDUCATIONAL EXCELLENCE (PSEE) - IN 2014, SEVENTEEN INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED WATERBURY'S PSEE, A 12-WEEK CURRICULUM CO-CREATED BY THE CONNECTICUT CENTER FOR SCHOOL

Part VI Supplemental Information *(Continuation)*

CHANGE AND THE CONNECTICUT COMMISSION ON CHILDREN FOR PARENTS (DEFINED BROADLY AS PARENTS, GUARDIANS, FAMILY MEMBERS AND GRANDPARENTS) TO INSTILL LEADERSHIP SKILLS IN EDUCATION AND TO FACILITATE PARTNERSHIPS BETWEEN SCHOOL STAFF AND PARENTS TO IMPROVE STUDENT LEARNING.

- UCONN PEOPLE EMPOWERING PEOPLE (PEP) OFFERED IN SPANISH AND ALBANIAN - BOTH FREE INAUGURAL PROGRAMS WERE HELD IN 2014. THE PROGRAMS INCLUDED A 10-WEEK PARENT LEADERSHIP AND ADVOCACY REGIMEN THROUGH WHICH 9 PARTICIPANTS SUCCESSFULLY COMPLETED THE ALBANIAN PORTION OF THE PEP COURSE AND 21 PARTICIPANTS COMPLETED THE SPANISH PORTION OF THE PEP COURSE. UCONN PEP IS A PERSONAL, FAMILY, AND LEADERSHIP DEVELOPMENT PROGRAM WITH A STRONG COMMUNITY FOCUS. PEP IS DESIGNED TO BUILD ON THE UNIQUE STRENGTHS AND LIFE EXPERIENCES OF PARTICIPANTS AND EMPHASIZES THE CONNECTION BETWEEN INDIVIDUAL AND COMMUNITY ACTION. BOTH UCONN PEP PROGRAMS ARE SIGNIFICANT FOR TWO REASONS; IT WAS THE FIRST TIME THAT A UCONN PEP COURSE HAS BEEN OFFERED IN BOTH ALBANIAN AND SPANISH AT WATERBURY HOSPITAL. HOWEVER IT IS ALSO THE FIRST TIME AN ALBANIAN AND SPANISH PARENT LEADERSHIP PROGRAM IS OFFERED WITH IN THE STATE OF CONNECTICUT. PARTICIPANTS OF BOTH PROGRAMS WORK INDIVIDUALLY OR COLLABORATIVELY TO CREATE A COMMUNITY PROJECT WHICH IS COMPLETED AS THE CONCLUDING PORTION OF THE PROGRAM. AN EXAMPLE OF A COMMUNITY PROJECT FROM 2014 INCLUDE: THE "UCONN ALBANIAN PEOPLE EMPOWERING PEOPLE (PEP) RESOURCE FAIR" THROUGH COLLABORATIVE EFFORT MEMBERS OF THE PLTI - ALBANIAN PEP ASSEMBLY REACHED OUT TO SENATOR JOAN HARTLEY IN AN EFFORT TO ADDRESS CHALLENGING LANGUAGE BARRIERS FACED BY MEMBERS OF THE COMMUNITY WHEN UTILIZING VARIOUS DMV SERVICES. TOGETHER THEY WERE ABLE TO BRING THESE CONCERNS TO THE ATTENTION OF CONNECTICUT LEGISLATIVES AND AS A RESULT ENACTED POSITIVE CHANGE FOR THE ALBANIAN COMMUNITY THROUGH THE CREATION OF A USER FRIENDLY COMMUNICATION INTERFACE ALLOWING THE OPTION OF

Part VI Supplemental Information *(Continuation)*

THE ALBANIAN LANGUAGE TO BE DISPLAYED ON VARIOUS FORMS AND WEB SERVICES.

- WH SUMMER BRIDGE PROGRAM - DURING THE SUMMER OF 2014, TWENTY-EIGHT STUDENTS FROM WATERBURY, GRADES 6-11, PARTICIPATED IN THE WH SUMMER BRIDGE PROGRAM. 100% OF MEALS WERE SECURED FOR THE PROGRAM FROM CITY OF WATERBURY SUMMER FOOD PROGRAM.

STUDENTS COMPLETED THE FOLLOWING MODULES:

- 12 HOURS OF MATH (PRE- ALGEBRA, ALGEBRA II, GEOMETRY AND CALCULUS) REVIEW SESSIONS

- 20 HOURS OF SAT WRITING AND VOCABULARY

- 18 HOURS OF PHOTOVOICE PROJECT, STUDENTS WERE INSTRUCTED ON PHOTOGRAPHY TECHNIQUES, COMPOSITION, AND EDITING USING ADOBE PHOTOSHOP SOFTWARE AND SLR CAMERAS

- 6 HOURS OF ESSAY WRITING

- 11 HOURS OF POETRY INSTRUCTION AND PARTICIPATION IN THE SECOND ANNUAL WH POETRY SLAM

- 8 HOURS OF JOB SHADOWING SESSIONS IN THE FOLLOWING DEPARTMENTS: NURSING, HEALTH INFORMATION MANAGEMENT, HUMAN RESOURCES, RESPIRATORY THERAPY, WATERBURY HEALTH ACCESS PROGRAM, MORRISON FOOD SERVICES & NUTRITION, FINANCE, INFECTIOUS DISEASES CLINIC, LAB, PHARMACY, CENTRAL SCHEDULING, PLANT ENGINEERING, HAROLD LEEVER REGIONAL CANCER CENTER, AMERICAN MEDICAL REPONSES, AND CLINICAL EDUCATION, WHICH INCLUDED PARTICIPATING IN CLASSES SPONSORED BY THE AMERICAN RED CROSS (CPR AND BABYSITTING).

- CPR & AMERICAN RED CROSS CERTIFIED BABYSITTING COURSE.

- 2 HOURS OF MS OFFICE COMPUTER SESSIONS

- 6 HOUR SCIENCE MODULE AT STONE ACADEMY

Part VI **Supplemental Information** *(Continuation)*

- 2 FULL-DAY FIELD TRIPS COMPLETED: ONE TO YALE UNIVERSITY FOR AN ADMISSIONS INFO SESSION AND CAMPUS TOUR AND ONE TO HAMMONASSET STATE PARK INCLUDING THREE EDUCATIONAL SESSIONS AT MEIGS POINT NATURE CENTER

- 2 HOURS OF COLLEGE ADMISSIONS PRESENTATIONS COMPLETED BY UCONN WATERBURY & NAUGATUCK VALLEY COMMUNITY COLLEGE

- 1 HOUR OF INDIVIDUAL ACADEMIC ADVISING

- 2 HOURS OF HR ORIENTATION & SOFT SKILLS TRAINING

- 10 HOURS OF SOCIAL DETERMINANTS OF HEALTH DOCUMENTARIES AND ACTIVE DISCUSSIONS WITH THE WATERBURY DEPARTMENT OF PUBLIC HEALTH

- PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) - SINCE ITS INCEPTION IN 2004, WATERBURY HOSPITAL'S PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) PROGRAM HAS ENGAGED ADMINISTRATORS, TEACHERS, AND STUDENTS FROM MIDDLE SCHOOLS IN GREATER WATERBURY TO ADDRESS PROJECTED SHORTAGES OF HEALTHCARE WORKERS AND TO CLOSE THE ACHIEVEMENT GAP FOR STUDENTS IN WATERBURY PUBLIC SCHOOLS. THROUGH THE PEACH PROGRAM, STUDENTS ENGAGE WITH HEALTHCARE WORKERS IN A NON-EMERGENCY SETTING AND ARE INFORMED OF THE VARIETY OF HEALTHCARE CAREER OPPORTUNITIES AVAILABLE IN OUR COMMUNITY. ANNUALLY, WATERBURY HOSPITAL ALSO OFFERS ITS PEACH SPRING BREAK EXPLORATION CAMP, THIS YEAR 48 MIDDLE SCHOOL STUDENTS FROM WATERBURY TOOK PART IN: SHADOWING AND HANDS-ON LEARNING ACTIVITIES AT THE HOSPITAL; CPR CERTIFICATION; BABYSITTING; AND EDUCATIONAL SESSIONS AT THE MYSTIC AQUARIUM.

SUPPORT GROUPS - DURING FISCAL YEAR 2014, WATERBURY HOSPITAL HOSTED SEVERAL SUPPORT GROUPS FOR ITS PATIENTS AND THEIR FAMILIES, INCLUDING:

- BEHAVIORAL HEALTH'S PARENT AND SIBLING SUPPORT GROUP, WHICH OFFERS EMOTIONAL ASSISTANCE TO FAMILIES WHO HAVE CHILDREN IN TREATMENT; AND

Part VI Supplemental Information *(Continuation)*

- ALCOHOLICS ANONYMOUS, SERVES OVER 4,000 PEOPLE ANNUALLY, MEETS WEEKLY THROUGHOUT THE YEAR, AND IS COORDINATED BY OUR BEHAVIORAL HEALTH DEPARTMENT.

PART III, LINE 2:

OVERALL COST TO CHARGE RATIO USED IN CALCULATION.

PART III, LINE 3:

FINANCIAL ASSISTANCE (CHARITY CARE) IS A SEPARATE NUMBER, AND NOT INCLUDED IN THE $871,605 ON LINE 2.

PART III, LINE 4:

THE HOSPITAL ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. A PATIENT IS CLASSIFIED AS A CHARITY PATIENT BY REFERENCE TO THE ESTABLISHED POLICIES OF THE HOSPITAL. ESSENTIALLY, THESE POLICIES DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO PAYMENT IS POSSIBLE. IN ASSESSING A PATIENT'S INABILITY TO PAY, THE HOSPITAL UTILIZES THE GENERALLY RECOGNIZED FEDERAL POVERTY INCOME LEVELS, BUT ALSO INCLUDES CERTAIN CASES WHERE INCURRED CHARGES ARE SIGNIFICANT WHEN COMPARED TO INCOMES AND ASSETS. THESE SERVICES ARE NOT INCLUDED IN NET PATIENT SERVICE REVENUES FOR FINANCIAL REPORTING PURPOSES. EFFECTIVE OCTOBER 1, 2013, THE HOSPITAL CHANGED ITS CHARITY CARE POLICY TO DISCOUNT ALL SELF PAY RECEIVABLES BY 50% UPON FINAL BILLING.

PART III, LINE 8:

COSTING METHODOLOGY USED TO COMPUTE THE MEDICARE SHORTFALL AND ANY ASSOCIATED COMMUNITY BENEFIT IS A COMBINATION OF THE AMOUNT REPORTED ON LINE 7 AS WELL AS THE HEALTH PROFESSION EDUCATION LINE. A

Part VI Supplemental Information *(Continuation)*

TOTAL SHORTFALL OF $7,750,927 WAS DERIVED FROM THE 2014 MEDICARE COST REPORT USING AN AHA APPROVED FORM FOR SCHEDULE H WORKSHEET B PPS AND IPF HOSPITALS. ALL OF THIS SHORTFALL SHOULD BE REPORTED AS A COMMUNITY BENEFIT. THE HOSPITAL COST ACCOUNTING SYSTEM SHOWS A SHORTFALL FROM ALL MEDICARE PROGRAMS (INCLUDING MANAGED MEDICARE) OF $12,528,626 (NET OF BAD DEBT AND FREE CARE).

PART III, LINE 9B:

WE HAVE SEVERAL CREDIT AND COLLECTION PROGRAMS GOVERNING PATIENTS WHO QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE; PROMPT PAY DISCOUNT; SLIDING SCALE; PAYMENT ARRANGEMENTS; CHARITY CARE AND FREE BED FUNDS. ANY PATIENT EXPRESSING DIFFICULTY PAYING A BALANCE IS ENTITLED TO APPLY FOR FINANCIAL COUNSELING ASSISTANCE. CUSTOMER SERVICE REPRESENTATIVES WORK WITH THE PATIENTS TO DETERMINE PROGRAM QUALIFICATION BASED ON THE COMPLETION OF A FINANCIAL APPLICATION. CASES ARE PREPARED AND PRESENTED TO THE PATIENT ASSISTANCE COMMITTEE. APPROVED CASES WILL BE EITHER FULLY OR PARTIALLY WRITTEN OFF TO FREE BED FUNDS OR CHARITY CARE.

PART VI, LINE 2:

WATERBURY HOSPITAL WORKS CLOSELY WITH LOCAL HEALTHCARE PROVIDERS AND COMMUNITY-BASED ORGANIZATIONS TO IDENTIFY HEALTHCARE NEEDS FOR UNDERSERVED PATIENTS THROUGHOUT THE WATERBURY COMMUNITY. THROUGH THESE COLLABORATIONS, WATERBURY HOSPITAL WORKS TO DEVELOP KEY PROGRAMMING FOR THE CITY'S VULNERABLE POPULATIONS, INCLUDING: THE WATERBURY HOSPITAL INFECTIOUS DISEASE CLINIC, WHICH PROVIDES COMPREHENSIVE HIV CARE TO ABOUT 500 PEOPLE LIVING WITH HIV/AIDS; THE WATERBURY HEALTH ACCESS PROGRAM, WHICH PROVIDES COMPREHENSIVE CASE MANAGEMENT SERVICES TO OVER 4,000 UNINSURED AND UNDERINSURED PATIENTS ANNUALLY; AND THE WATERBURY HOSPITAL

Part VI **Supplemental Information** *(Continuation)*

CHASE DIABETES DISEASE MANAGEMENT CLINIC, WHICH PROVIDES 60-70 DIABETICS WITH SELF-MANAGEMENT SKILLS AND CLINICAL CARE.

PART VI, LINE 3:

WE HAVE SIGNAGE, PT HANDBOOK, STATEMENT BACKERS & HANDOUTS THAT INFORM PATIENTS OF FREE BED FUNDS ETC. THE HOSPITAL ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. A PATIENT IS CLASSIFIED AS A CHARITY PATIENT BY REFERENCE TO THE ESTABLISHED POLICIES OF THE HOSPITAL. ESSENTIALLY, THESE POLICIES DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO PAYMENT IS POSSIBLE. IN ASSESSING A PATIENT'S INABILITY TO PAY, THE HOSPITAL UTILIZES THE GENERALLY RECOGNIZED POVERTY INCOME LEVELS FOR THE STATE, BUT ALSO INCLUDES CERTAIN CASES WHERE INCURRED CHARGES ARE SIGNIFICANT WHEN COMPARED TO INCOMES. THESE CHARGES ARE NOT INCLUDED IN NET PATIENT SERVICE REVENUES FOR FINANCIAL REPORTING PURPOSES.

PART VI, LINE 4:

LOCATED IN A CITY OF 109,000 RESIDENTS, WATERBURY HOSPITAL IS CENTRALLY LOCATED IN WESTERN CONNECTICUT. IT IS ONE OF TWO HOSPITALS THAT SERVES THE CITY OF WATERBURY AND ITS SURROUNDING TOWNS, INCLUDING BEACON FALLS, BETHLEHEM, CHESHIRE, MIDDLEBURY, NAUGATUCK, PROSPECT, SOUTHBURY, THOMASTON, WATERTOWN, WOLCOTT, AND WOODBURY. OVERALL, THE CITY OF WATERBURY LAGS BEHIND THE STATE OF CONNECTICUT AND THE U.S. IN KEY MEASURABLE STATISTICS, AS SEEN IN TABLE 1, BELOW:

TABLE 1: SELECTED CENSUS DATA, JULY 2013, QUICKFACTS.CENSUS.GOV: WATERBURY, CT, & U.S.

	WATERBURY	CT	U.S.
MEDIAN HOUSEHOLD INCOME:	$40,639	$69,461	$52,762

Part VI **Supplemental Information** *(Continuation)*

PER CAPITA MONEY INCOME:	$21,120	$37,892	$27,915
% PERSONS BELOW POVERTY:	23.3%	10.2%	14.3%
% HOUSEHOLDS MARRIED COUPLE FAMILY:	34.6%	49.4%	49.7%
% OF OWNER-OCCUPIED HOMES:	47.4%	67.8%	66.9%
% FOREIGN-BORN PERSONS:	14.6%	13.6%	12.8%
% LANGUAGE NOT ENGLISH SPOKEN AT HOME, AGE 5+:	36.1%	21.5%	20.3%
% HOUSEHOLDS WITH NO VEHICLE:	16.8%	9.0%	8.8%
% MALE:	47.6%	48.7%	49.2%
% FEMALE	52.4%	51.3%	50.8%
% CAUCASIAN:	59.9%	77.9%	63.0%
% AFRICAN-AMERICAN:	19.8%	10.1%	13.1%
% HISPANIC:	33.8%	13.9%	16.9%
% HIGH SCHOOL GRADUATES OR HIGHER:	78.8%	89.2%	84.6%
% BACHELOR'S DEGREE OR HIGHER:	16.1%	36.5%	27.5%
% OF PERSONS AGE 65 & OVER:	10.5%	10.8%	13.7%
UNEMPLOYMENT RATE, MAY 2013:	8.7%	6.6%	7.6%
INFANT MORTALITY PER 1,000 RESIDENTS:	9.83	6.2	6.8
CRIME RATE (VIOLENT & PROPERTY) PER 100,000 RESIDENTS (2009):	6,379	2,981	3,466

WATERBURY WAS ONCE A ROBUST MANUFACTURING CENTER. HOWEVER, OVER THE PAST 25 YEARS, THE INDUSTRIAL BASE THAT WAS THE CENTER OF WATERBURY'S ECONOMY FOR MOST OF THE 20TH CENTURY DWINDLED, LEAVING MANY UNEMPLOYED. ALTHOUGH THERE ARE JOBS AVAILABLE IN HEALTHCARE AND SERVICE SECTORS, HIGH UNEMPLOYMENT REMAINS A THREAT FOR MANY INDIVIDUALS IN THE GREATER WATERBURY AREA. THE CITY OF WATERBURY IS ALSO DESIGNATED A FEDERAL MUA

Part VI **Supplemental Information** *(Continuation)*

(MEDICALLY UNDERSERVED AREA) AND HPSA (HEALTH PROFESSIONAL SHORTAGE AREA) FOR PRIMARY CARE, MENTAL HEALTH, AND DENTAL CARE.

PART VI, LINE 5:

REALIZING THE DIVERSE NEEDS OF RESIDENTS IN OUR COMMUNITY, WATERBURY HOSPITAL REMAINS DEDICATED TO PROVIDING COMPREHENSIVE HEALTH SERVICES TO ENSURE EVERY INDIVIDUAL HAS ACCESS TO APPROPRIATE, QUALITY HEALTHCARE.

DURING 2014, WATERBURY HOSPITAL'S SPECTRUM OF SERVICES CONTINUED TO HAVE A POSITIVE IMPACT ON THE WELFARE OF WATERBURY'S CITIZENS. TO REMAIN CONSISTENT WITH WATERBURY HOSPITAL'S MISSION, MANY OF OUR SERVICES ARE TARGETED FOR VULNERABLE MEMBERS OF OUR COMMUNITY, INCLUDING THOSE WHO ARE UNINSURED OR UNDERINSURED.

KEY PROGRAMS:

WATERBURY HEALTH ACCESS PROGRAM: WATERBURY HOSPITAL IS AWARE OF THE ECONOMIC NEEDS MANY PATIENTS IN OUR COMMUNITY, AND, AS A RESULT, WE REMAIN COMMITTED TO THE WATERBURY HEALTH ACCESS PROGRAM. FOUNDED IN 2003 AS A PARTNERSHIP BETWEEN WATERBURY HOSPITAL, ST. MARY'S HOSPITAL, STAYWELL HEALTH CENTER (FQHC), AND THE WATERBURY HEALTH DEPARTMENT, THE WATERBURY HEALTH ACCESS PROGRAM IMPROVES ACCESS TO HIGH-QUALITY MEDICAL CARE BY PROVIDING COMPREHENSIVE CASE MANAGEMENT, PHARMACY ASSISTANCE, AND ACCESS TO PRIMARY AND SUB-SPECIALTY MEDICAL CARE FOR THE UNINSURED AND UNDERINSURED RESIDENTS OF THE GREATER WATERBURY REGION. DURING FY 2014, THE WATERBURY HEALTH ACCESS PROGRAM HAD OVER 4,370 ACTIVE CLIENTS. ADDITIONALLY, WATERBURY HOSPITAL PROVIDED $402,864 WORTH OF DONATED

Part VI Supplemental Information *(Continuation)*

SERVICES TO WHAP'S PATIENTS.

BEHAVIORAL HEALTH - WATERBURY HOSPITAL'S CENTER FOR BEHAVIORAL HEALTH IS ONE OF THE REGION'S LARGEST SERVICE PROVIDERS OFFERING A FULL CONTINUUM OF CARE FOR CHILDREN, ADOLESCENTS AND ADULTS. OUR SERVICES ALSO OUTREACH TO THE COMMUNITY THROUGH REGULAR PARTICIPATION IN HEALTH FAIRS, ELECTED MEMBERSHIP IN THE NORTHWEST REGIONAL MENTAL HEALTH BOARD, AS A HOST SITE TO NUMEROUS TWELVE-STEP MEETINGS AND THE PROVISION OF CASE MANAGEMENT AS WELL AS ACUTE SERVICES TO THE HOMELESS WITHIN THE CITY OF WATERBURY. BEHAVIORAL HEALTH CLINICIANS CAN ENGAGE CLIENTS TO HELP FACILITATE THEIR ENTRANCE INTO TREATMENT. WE PROVIDE PHONE SUPPORT, REFERRALS AND TRIAGING TEN HOURS A DAY SEVEN DAYS A WEEK. WITHIN OUR CRISIS CENTER WE OFFER SHORT TERM SERVICES TO HELP INDIVIDUALS OBTAIN MORE PERMANENT TREATMENT THAT BEST MEETS THEIR NEEDS. AMBULATORY SERVICES INCLUDE PARTIAL HOSPITAL PROGRAMS, INTENSIVE OUTPATIENT SERVICES, GROUP, INDIVIDUAL THERAPY AND MEDICATION MANAGEMENT TO PATIENTS EXPERIENCING MENTAL ILLNESS AND/ OR A SUBSTANCE USE DISORDER. FOR INDIVIDUALS EXPERIENCING ACUTE SYMPTOMS WE OFFER INPATIENT TREATMENT TO ADOLESCENTS AGED 12 AND UP AS WELL AS ADULT SERVICES. OUR EFFORTS ARE AIMED AT PROMOTING THE BENEFITS OF CLINICAL TREATMENT AS WELL AS POSITIVE LIFESTYLE CHOICES. EVERY EFFORT IS MADE TO EDUCATE CLIENTS, THEIR FAMILIES AND THE COMMUNITY ABOUT MENTAL ILLNESS AND THE IMPACT TREATMENT CAN HAVE ON ONE'S ILLNESS. THE ULTIMATE GOAL IS TO HELP PEOPLE FEEL BETTER, REDUCE OR RESOLVE SYMPTOMS AND TO MINIMIZE THE STIGMA OF MENTAL ILLNESS.

BE WELL BUS - IN ORDER TO ENSURE THAT PATIENTS HAVE ACCESS TO MEDICAL APPOINTMENTS, AT THE HOSPITAL AND AT LOCAL PHYSICIANS' OFFICES, WATERBURY HOSPITAL'S BE WELL BUS PROVIDES TRANSPORTATION SERVICES TO PATIENTS FROM

Part VI Supplemental Information *(Continuation)*

WATERBURY AND ELEVEN OF ITS SURROUNDING TOWNS. DURING FY 2014, THE BE WELL BUS COMPLETED OVER 4,170 TRANSPORTS TO AND FROM MEDICAL APPOINTMENTS. WATERBURY HOSPITAL HAS CONTRACTED WITH A TRANSPORTATION PROVIDE TO OFFER THE BUS SERVICE, AND AREA PROVIDERS PAY A SMALL FEE TO PARTICIPATE.

HEART CENTER OF GREATER WATERBURY - FORMED IN COLLABORATION WITH SAINT MARY'S HOSPITAL, THE HEART CENTER OF GREATER WATERBURY PROVIDES DIVERSE MEDICAL SUPPORT INITIATIVES TO HELP EDUCATE RESIDENTS IN THE GREATER WATERBURY COMMUNITY ABOUT PERTINENT HEALTH AND WELLNESS ISSUES. THIS PAST YEAR, THE HEART CENTER CONDUCTED A SERIES OF HEALTH FAIRS AND VARIOUS HEALTH AND WELLNESS EDUCATION SESSIONS, INCLUDING "ASK THE NURSE," WHICH PROVIDES PATIENTS WITH COMPLIMENTARY BLOOD PRESSURE SCREENINGS AND HEALTH AWARENESS EDUCATION AND A "FREEDOM FROM SMOKING" SERIES TO HELP OUR RESIDENTS KICK THE HABIT.

FAMILY BIRTHING CENTER - PROVIDING A CHILD-CENTERED FOCUS, WATERBURY HOSPITAL'S FAMILY BIRTHING CENTER OFFERS EXPECTANT PARENTS A VARIETY OF CLASSES INCLUDING: BREAST FEEDING, CHILDBIRTH, AND INFANT CARE CLASSES TO PREPARE THEM FOR THEIR BABY'S ARRIVAL.

THANK GOD I'M FEMALE - FOR THE PAST 20 YEARS, WATERBURY HOSPITAL'S "THANK GOD I'M FEMALE" HAS SERVED AS AN ANNUAL WOMEN'S WELLNESS FORUM THAT FEATURES 40 EDUCATIONAL BOOTHS AND HEALTH-RELATED GIVEAWAYS. THE ULTIMATE GOAL OF THE FORUM IS TO EDUCATE ATTENDEES ABOUT STRESS, MENTAL WELL-BEING, HEART HEALTH, DIET, OSTEOPOROSIS AND BONE HEALTH, CHANGE OF LIFE, AND MORE. IN 2014, OVER 500 AREA RESIDENTS ATTENDED THE EVENT.

EVERGREEN 50 CLUB - WATERBURY HOSPITAL'S EVERGREEN 50 CLUB IS AN

Part VI Supplemental Information *(Continuation)*

ORGANIZATION COMPRISED OF OVER 15,000 MEMBERS OVER THE AGE OF 50. THE CLUB OFFERS WELLNESS PROGRAMMING, MEDICARE COUNSELING, AND HEALTH EDUCATION PRESENTATIONS ON A VARIETY OF TOPICS ARE PRESENTED BY HEALTH CARE PROFESSIONALS. PRESENTATION TOPICS INCLUDE: HOLISTIC HEALTH, VARICOSE VEIN TREATMENT, HEART DISEASE, SUMMER SKIN CARE, WEIGHT LOSS, BLOOD PRESSURE, BLADDER SCREENINGS, JOINT CARE AND REPLACEMENT, AND RESOLVING ADVERSE OUTCOMES WITH PATIENTS AND FAMILIES. ANNUALLY, THE EVERGREEN 50 CLUB HOSTS A HEALTH FAIR FOR ITS MEMBERS, WHICH PROVIDES FREE FLU SHOTS AND HEALTHCARE SCREENINGS.

WATERBURY HOSPITAL INFECTIOUS DISEASE CLINIC (WHIC) -

CURRENT SERVICES: THE WHIC OFFERS A COMPREHENSIVE "ONE-STOP SHOPPING" MODEL THAT PROVIDES PATIENTS WITH ON-SITE PRIMARY AND SPECIALTY SERVICES, MEDICAL CASE MANAGEMENT, INDIVIDUALIZED MEDICATION ADHERENCE SERVICES, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, NUTRITION COUNSELING, INDIVIDUALIZED HIV EDUCATION, LABORATORY TESTING, AND RADIOLOGY SERVICES. WHIC'S PROVIDERS INCLUDE THREE BOARD-CERTIFIED/BOARD-ELIGIBLE INFECTIOUS DISEASE SPECIALISTS AS WELL AS AN ADVANCED PRACTITIONER NURSE AND A REGISTERED DIETICIAN, ALL WITH EXPERTISE IN THE MANAGEMENT OF PATIENTS WITH HIV/AIDS. IN FY 2014, WHIC SERVED AROUND 500 PEOPLE LIVING WITH HIV/AIDS (PLWHA).

WHIC'S STAFF MEMBERS ACTIVELY PARTICIPATE IN STATEWIDE AND AREA COLLABORATIVE, SUCH AS THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC) AND THE RYAN WHITE PART A PLANNING COUNCIL, AND WHIC FACILITATES THE GREATER WATERBURY HIV CONSORTIUM. WHIC HAS A VERY ACTIVE CONSUMER ADVISORY GROUP (CAG), WHICH ORGANIZES SOCIAL AND TESTING EVENTS FOR THE COMMUNITY AND FACILITATES THE WATERBURY HOSPITAL PHOTOGRAPHY GROUP.

THE WHIC ALSO HAS A HEPATITIS C CLINIC, RUN BY AN ADVANCED PRACTITIONER NURSE. FROM OCTOBER 2004 TO PRESENT, NEARLY 200 HEPATITIS C MONO- AND CO-INFECTED (HEPATITIS C AND HIV) PATIENTS HAVE BEEN EVALUATED AT THE ID CLINIC. THE HEPATITIS C CLINIC PROVIDES A CONSULTATION WITH A NUTRITIONIST TO ADVISE ON HEALTHY EATING; COORDINATION WITH MENTAL HEALTH SERVICES; AND EDUCATIONAL SESSIONS ON SIDE EFFECT MANAGEMENT, THE IMPORTANCE OF HYDRATION AND ADHERENCE, AND POSITIVE COPING STRATEGIES.

FORGING COMMUNITY PARTNERSHIPS: SINCE 2009, THE WHIC HAS SERVED AS THE LEAD AGENCY FOR RYAN WHITE PART A FEDERAL FUNDING REGION 2 OF THE NEW HAVEN/FAIRFIELD ELIGIBLE METROPOLITAN AREA. THE WHIC WAS CHOSEN AS LEAD AGENCY BY THE CONSENSUS OF OTHER LOCAL RYAN WHITE PART A AGENCIES DUE TO ITS EXPERTISE IN PATIENT CARE AND FISCAL MANAGEMENT. AS THE LEAD AGENCY, THE WHIC HAS FORMED LONGSTANDING PARTNERSHIPS WITH STAYWELL HEALTH CENTER, INC., NEW OPPORTUNITIES, INC., RECOVERY NETWORK OF PROGRAMS, INC., AND CONNECTICUT COUNSELING CENTERS, INC., ALL OF WHOM WORK ALONGSIDE THE WHIC TO PROVIDE PATIENTS IN THE REGION WITH:

- PRIMARY HIV CARE;
- MEDICAL CASE MANAGEMENT;
- ORAL HEALTH CARE;
- INPATIENT AND OUTPATIENT SUBSTANCE ABUSE TREATMENT;
- HEALTH INSURANCE ASSISTANCE;
- MENTAL HEALTH;
- EARLY INTERVENTION SERVICES;
- HOUSING ASSISTANCE;
- EMERGENCY FINANCIAL ASSISTANCE;
- MEDICAL TRANSPORTATION; AND

Part VI **Supplemental Information** *(Continuation)*

- FOOD PANTRY.

IN JUNE 2014, WHIC COLLABORATED WITH THE WATERBURY HEALTH DEPARTMENT, GRACE BAPTIST CHURCH, AND OTHER AREA AIDS SERVICE ORGANIZATIONS, TO ORGANIZE THE WATERBURY AIDS WALK AND RAISE AWARENESS ABOUT HIV/AIDS TREATMENT AND TESTING IN WATERBURY. OVER 200 RESIDENTS PARTICIPATED IN THE EVENT.

PART VI, LINE 6:

N/A

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CT

PART VI, LINE 5 (CONTINUED):

RESHAPING HIV TESTING STATEWIDE: SINCE 2008, PATIENTS VISITING WATERBURY HOSPITAL'S EMERGENCY DEPARTMENT ARE OFFERED FREE HIV SCREENING WHILE WAITING TO BE EVALUATED OR TREATED FOR OTHER SYMPTOMS. IN ORDER TO OPTIMIZE THE NUMBER OF PEOPLE SCREENED FOR HIV, THE EMERGENCY DEPARTMENT'S PROGRAM USES AN OPT-OUT APPROACH. THE PROGRAM HAS SUCCESSFULLY SERVED AS A MODEL FOR OTHER HEALTHCARE INSTITUTIONS ACROSS THE STATE. THANKS, IN PART, TO WHIC'S LEADERSHIP, THE STATE OF CONNECTICUT NO LONGER LEGALLY REQUIRES PROVIDERS TO HAVE A SEPARATE CONSENT FORM FOR HIV TESTING.

ENGAGING PATIENTS: IN 2009, THE WHIC ESTABLISHED ITS PEER ADVOCATE PROGRAM. THREE PATIENTS FROM THE CLINIC SERVE AS THE PEER ADVOCATES,

Part VI Supplemental Information *(Continuation)*

WHO WORK WITH CLIENTS AT THE CLINIC AND USE A SOCIAL NETWORKS STRATEGY TO BRING DIFFICULT-TO-REACH CLIENTS IN FOR TESTING AND/OR CARE; THEY HAVE TRAVELED TO HIGH-RISK NEIGHBORHOODS ON THE WATERBURY HEALTH DEPARTMENT'S COMMUNITY HEALTH VAN TO OFFER COUNSELING AND TESTING AND HAVE PARTICIPATED IN AIDS AWARENESS DAYS TO FACILITATE THE LINKAGE OF NEWLY DIAGNOSED PATIENTS TO PRIMARY CARE. PEER ADVOCATES PARTICIPATE IN THE WHIC'S CARE TEAM AND CONTINUUM MEETINGS TO KEEP PROVIDERS AND LOCAL PARTNERS AWARE OF THE PATIENTS' ACTIVITIES AND NEEDS.

THIS YEAR ONE PEER ADVOCATE PARTICIPATED IN THE WATERBURY PARENT LEADERSHIP TRAINING INSTITUTE, COMPLETING A COMMUNITY PROJECT, "JOSE'S HAVEN," TO PROVIDE SUPPORT SERVICES, ENROLL CLIENTS IN INDIVIDUAL PHOTO DIARY PROJECTS, AND ENCOURAGE VOLUNTEERISM.

THE WHIC OFFERS ITS PATIENTS NATIONALLY-RECOGNIZED PEER AND SUPPORT PROGRAMS, INCLUDING ITS PROJECT PHOTOGRAPHY, WHICH WAS ESTABLISHED IN 2007 TO ENCOURAGE NON-COMPLIANT HIV/AIDS PATIENTS IN THE GREATER WATERBURY AREA TO BECOME MORE PROACTIVE IN THE SELF-MANAGEMENT OF THEIR DISEASE. PROJECT PHOTOGRAPHY HAS POSITIVELY TRANSFORMED ITS PARTICIPANT'S SELF-ESTEEM AND CONFIDENCE. PATIENT PROJECTS HAVE INCLUDED: (1) ENROLLING IN PHOTOGRAPHY CLASSES AT NAUGATUCK VALLEY COMMUNITY COLLEGE, (2) TAKING FIELD TRIPS, (3) DONATING FRAMED PHOTOGRAPHS TO THE HOSPITAL'S ANNUAL FUNDRAISING GALA AND PATIENT FLOORS, (4) PRODUCING HOLIDAY GREETING CARDS FOR THE ID CLINIC, (5) CREATING TEAM PORTRAITS AT THE HOSPITAL'S FUNDRAISING GOLF TOURNAMENT, AND (6) MOUNTING PHOTOGRAPHY EXHIBITS AT THE HOSPITAL, BARNES & NOBLE BOOKSTORE, AND SILAS BRONSON LIBRARY IN WATERBURY.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

▶ **Information about Schedule J (Form 990) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE WATERBURY HOSPITAL

Employer identification number

06-0665979

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2	X	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) DARLENE STROMSTAD	(i)	525,286.	51,500.	0.	82,650.	10,714.	670,150.	0.
PRESIDENT/TREASURER	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) DR. HENRY BORKOWSKI	(i)	750,082.	0.	0.	25,150.	12,310.	787,542.	0.
DIRECTOR / CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) DAVID J. PIZZUTO, MD	(i)	142,625.	31,159.	0.	5,202.	3,229.	182,215.	0.
DIRECTOR / VP MEDICAL SERVICES	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) SANDRA A. IADAROLA	(i)	204,007.	46,880.	0.	7,524.	9,167.	267,578.	0.
CHIEF NURSING OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DIANE M. WOOLLEY	(i)	180,957.	53,398.	0.	7,261.	17,430.	259,046.	0.
VP HUMAN RESOURCES	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) MICHAEL J. CEMENO	(i)	287,438.	66,805.	0.	7,650.	14,854.	376,747.	0.
CHIEF INFORMATION OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) THOMAS M. BURKE	(i)	173,802.	14,246.	0.	1,148.	15,895.	205,091.	0.
VICE PRESIDENT OPERATIONS	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) EHSAN ANSARI	(i)	876,277.	0.	0.	25,150.	16,697.	918,124.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) KEVIN KETT	(i)	861,837.	0.	0.	25,150.	16,697.	903,684.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) JOSEPH MORLEY	(i)	884,876.	0.	0.	25,150.	16,697.	926,723.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) MARK RUGGIERO	(i)	763,998.	0.	0.	25,150.	16,220.	805,368.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) STEPHEN WIDMAN	(i)	783,391.	0.	0.	25,150.	16,697.	825,238.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 4B:

DARLENE STROMSTAD'S SERP CONTRIBUTION: $75,000

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions. ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990

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Part I Bond Issues SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	CONNECTICUT HEALTH & EDUCATIONAL FACILITIES A	06-0806186	NONE	12/22/10	25918000.	REFINANCE/RETIRE EXISTING BONDS &		X	X			X
B												
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	19,435,000.			
2	Amount of bonds legally defeased	19,435,000.			
3	Total proceeds of issue	25,918,000.			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	403,696.			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	7,876,000.			
11	Other spent proceeds	18,042,000.			
12	Other unspent proceeds				
13	Year of substantial completion	2013			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X						
15	Were the bonds issued as part of an advance refunding issue?		X						
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X						

Part III Private Business Use *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X						
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	%		%		%		%	
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6	Total of lines 4 and 5	%		%		%		%	
7	Does the bond issue meet the private security or payment test?		X						
8a	Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X							

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?	X							
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?								
b	Exception to rebate?								
c	No rebate due?								
	If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X							
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X							
b	Name of provider	RBS CITIZEN'S N.A.							
c	Term of hedge	10.0000000							
d	Was the hedge superintegrated?		X						
e	Was the hedge terminated?		X						

Part IV Arbitrage *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X						
7 Has the organization established written procedures to monitor the requirements of section 148?	X							

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X							

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: CONNECTICUT HEALTH & EDUCATIONAL FACILITIES AUTHORITY
(F) DESCRIPTION OF PURPOSE:
REFINANCE/RETIRE EXISTING BONDS & FINANCE NEW MONEY FOR CAPITAL IMPROVEMENT

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

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Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 **(a)** Name of disqualified person	**(b)** Relationship between disqualified person and organization	**(c)** Description of transaction	**(d)** Corrected? Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	**(b)** Relationship with organization	**(c)** Purpose of loan	**(d)** Loan to or from the organization? To	From	**(e)** Original principal amount	**(f)** Balance due	**(g)** In default? Yes	No	**(h)** Approved by board or committee? Yes	No	**(i)** Written agreement? Yes	No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of assistance	**(d)** Type of assistance	**(e)** Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	No
DR. NEIL PETERSEN	TRUSTEE	56,250.	STIPEND FOR		X
CARL B. SHERTER	TRUSTEE	18,750.	STIPEND FOR		X
DR. NEIL PETERSEN	TRUSTEE	745,300.	DR. NEIL PE		X
DR. HENRY BORKOWSKI	TRUSTEE	138,880.	RENT FOR CA		X

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: DR. NEIL PETERSEN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

TRUSTEE

(C) AMOUNT OF TRANSACTION $ 56,250.

(D) DESCRIPTION OF TRANSACTION: STIPEND FOR SERVING AS CHIEF OF STAFF

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: CARL B. SHERTER

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

TRUSTEE

(C) AMOUNT OF TRANSACTION $ 18,750.

(D) DESCRIPTION OF TRANSACTION: STIPEND FOR SERVING AS CHIEF OF STAFF

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: DR. NEIL PETERSEN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

TRUSTEE

(C) AMOUNT OF TRANSACTION $ 745,300.

(D) DESCRIPTION OF TRANSACTION: DR. NEIL PETERSEN IS AN EMPLOYEE OF

Part V **Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

WATERBURY ANESTHESIOLOGY ASSOCIATES, WHICH PROVIDED ANESTHESIA SERVICES FOR THE WATERBURY HOSPITAL.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: DR. HENRY BORKOWSKI

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: TRUSTEE

(C) AMOUNT OF TRANSACTION $ 138,880.

(D) DESCRIPTION OF TRANSACTION: RENT FOR CARDIOLOGY ASSOCIATES OF GREATER WATERBURY, LLC OFFICE SPACE

(E) SHARING OF ORGANIZATION REVENUES? = NO

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

FAMILY OF PROFESSIONALS AND SERVICES.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS (CONTINUED):

TOTAL COMMUNITY BENEFITS FOR FY 2014 BY CATEGORY:

A. COMMUNITY HEALTH IMPROVEMENT SERVICES & COMMUNITY BENEFIT OPERATIONS

BENEFIT: $8,848,738

PERSONS SERVED: 25,237

- COMMUNITY HEALTH EDUCATION
- COMMUNITY-BASED CLINICAL SERVICES
- HEALTH CARE SUPPORT SERVICES

B. HEALTH PROFESSIONS EDUCATION

BENEFIT: $9,670,648

PERSONS SERVED: 1,689

- PHYSICIANS/MEDICAL STUDENTS
- NURSES/NURSING STUDENTS
- OTHER HEALTH PROFESSIONS EDUCATION
- SCHOLARSHIPS/FUNDING FOR PROFESSIONAL EDUCATION
- OTHER

D. RESEARCH

BENEFIT: $5,580

PERSONS SERVED: 17

- CLINICAL RESEARCH

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- COMMUNITY HEALTH RESEARCH

E. FINANCIAL AND IN-KIND CONTRIBUTIONS

BENEFIT: $108,982

PERSONS SERVED: 112,275

- CASH DONATIONS

- IN-KIND DONATIONS

F. COMMUNITY BUILDING ACTIVITIES

BENEFIT: $274,171

PERSONS SERVED: 12,813

- COMMUNITY SUPPORT

- ENVIRONMENTAL IMPROVEMENTS

- LEADERSHIP DEVELOPMENT/TRAINING COMMUNITY MEMBERS/ YOUTH PIPELINE

- COALITION BUILDING

- OTHER

G. COMMUNITY BENEFIT OPERATIONS

BENEFIT: $5,012

PERSONS SERVED: N/A

- DEDICATED STAFF

SUBTOTAL FOR COMMUNITY BENEFITS: $18,913,131

SUBTOTAL FOR PERSONS SERVED: 152,031

TRADITIONAL CHARITY CARE COSTS

- FREE CARE: $818,261

- BAD DEBT: $517,687

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- UNPAID MEDICAID COSTS: $7,919,998

- UNPAID MEDICARE COSTS: $7,750,927

SUBTOTAL FOR CHARITY CARE COSTS BENEFIT: $17,006,873

TOTAL BENEFIT - FY 2014: $35,920,004

CATEGORY A: COMMUNITY HEALTH IMPROVEMENT SERVICES

TOTAL BENEFIT: $8,848,738

TOTAL PERSONS SERVED: 25,237

REALIZING THE DIVERSE NEEDS OF RESIDENTS IN OUR COMMUNITY, WATERBURY HOSPITAL REMAINS DEDICATED TO PROVIDING COMPREHENSIVE HEALTH SERVICES TO ENSURE EVERY INDIVIDUAL HAS ACCESS TO APPROPRIATE, QUALITY HEALTHCARE.

DURING 2014, WATERBURY HOSPITAL'S SPECTRUM OF SERVICES CONTINUED TO HAVE A POSITIVE IMPACT ON THE WELFARE OF WATERBURY'S CITIZENS. TO REMAIN CONSISTENT WITH WATERBURY HOSPITAL'S MISSION, MANY OF OUR SERVICES ARE TARGETED FOR VULNERABLE MEMBERS OF OUR COMMUNITY, INCLUDING THOSE WHO ARE UNINSURED OR UNDERINSURED.

KEY PROGRAMS:

WATERBURY HEALTH ACCESS PROGRAM

WATERBURY HOSPITAL IS AWARE OF THE ECONOMIC NEEDS MANY PATIENTS IN OUR COMMUNITY, AND, AS A RESULT, WE REMAIN COMMITTED TO THE WATERBURY HEALTH ACCESS PROGRAM. FOUNDED IN 2003 AS A PARTNERSHIP BETWEEN

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WATERBURY HOSPITAL, ST. MARY'S HOSPITAL, STAYWELL HEALTH CENTER (FQHC), AND THE WATERBURY HEALTH DEPARTMENT, THE WATERBURY HEALTH ACCESS PROGRAM IMPROVES ACCESS TO HIGH-QUALITY MEDICAL CARE BY PROVIDING COMPREHENSIVE CASE MANAGEMENT, PHARMACY ASSISTANCE, AND ACCESS TO PRIMARY AND SUB-SPECIALTY MEDICAL CARE FOR THE UNINSURED AND UNDERINSURED RESIDENTS OF THE GREATER WATERBURY REGION. DURING FY 2014, THE WATERBURY HEALTH ACCESS PROGRAM HAD OVER 4,370 ACTIVE CLIENTS. ADDITIONALLY, WATERBURY HOSPITAL PROVIDED $402,864 WORTH OF DONATED SERVICES TO WHAP'S PATIENTS.

BEHAVIORAL HEALTH - WATERBURY HOSPITAL'S CENTER FOR BEHAVIORAL HEALTH IS ONE OF THE REGION'S LARGEST SERVICE PROVIDERS OFFERING A FULL CONTINUUM OF CARE FOR CHILDREN, ADOLESCENTS AND ADULTS. OUR SERVICES ALSO OUTREACH TO THE COMMUNITY THROUGH REGULAR PARTICIPATION IN HEALTH FAIRS, ELECTED MEMBERSHIP IN THE NORTHWEST REGIONAL MENTAL HEALTH BOARD, AS A HOST SITE TO NUMEROUS TWELVE-STEP MEETINGS AND THE PROVISION OF CASE MANAGEMENT AS WELL AS ACUTE SERVICES TO THE HOMELESS WITHIN THE CITY OF WATERBURY. BEHAVIORAL HEALTH CLINICIANS CAN ENGAGE CLIENTS TO HELP FACILITATE THEIR ENTRANCE INTO TREATMENT. WE PROVIDE PHONE SUPPORT, REFERRALS AND TRIAGING TEN HOURS A DAY SEVEN DAYS A WEEK. WITHIN OUR CRISIS CENTER WE OFFER SHORT TERM SERVICES TO HELP INDIVIDUALS OBTAIN MORE PERMANENT TREATMENT THAT BEST MEETS THEIR NEEDS. FOR INDIVIDUALS EXPERIENCING ACUTE SYMPTOMS WE OFFER INPATIENT TREATMENT TO ADOLESCENTS AGED 12 AND UP AS WELL AS ADULT SERVICES. OUR EFFORTS ARE AIMED AT PROMOTING THE BENEFITS OF CLINICAL TREATMENT AS WELL AS POSITIVE LIFESTYLE CHOICES. EVERY EFFORT IS MADE TO EDUCATE CLIENTS, THEIR FAMILIES AND THE COMMUNITY ABOUT MENTAL ILLNESS AND THE IMPACT TREATMENT CAN HAVE ON ONE'S ILLNESS. THE ULTIMATE GOAL IS TO

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HELP PEOPLE FEEL BETTER, REDUCE OR RESOLVE SYMPTOMS AND TO MINIMIZE THE STIGMA OF MENTAL ILLNESS.

BE WELL BUS - IN ORDER TO ENSURE THAT PATIENTS HAVE ACCESS TO MEDICAL APPOINTMENTS, AT THE HOSPITAL AND AT LOCAL PHYSICIANS' OFFICES, WATERBURY HOSPITAL'S BE WELL BUS PROVIDES TRANSPORTATION SERVICES TO PATIENTS FROM WATERBURY AND ELEVEN OF ITS SURROUNDING TOWNS. DURING FY 2014, THE BE WELL BUS'S HOURS OF OPERATION ARE FROM 6:00 AM TO 6:00 PM MONDAY - FRIDAY. THE PROGRAM OFFERED TRANSPORTS TO AND FROM MEDICAL APPOINTMENTS. WATERBURY HOSPITAL HAS CONTRACTED WITH A TRANSPORTATION PROVIDE TO OFFER THE BUS SERVICE, AND AREA PROVIDERS PAY A SMALL FEE TO PARTICIPATE. COMMUNITIES SERVED INCLUDE: WATERBURY, WATERTOWN, THOMASTON, SOUTHBURY, MIDDLEBURY, NAUGATUCK, WOLCOTT, AND BEACON FALLS IN ADDITION TO WATERBURY HOSPITAL. THIS PROGRAM CURRENTLY HAS 13 PARTICIPATING DEPARTMENTS WHICH INCLUDE 59 PRACTICING PHYSICIANS AND SPECIALISTS.

HEART CENTER OF GREATER WATERBURY - FORMED IN COLLABORATION WITH SAINT MARY'S HOSPITAL, THE HEART CENTER OF GREATER WATERBURY PROVIDES DIVERSE MEDICAL SUPPORT INITIATIVES TO HELP EDUCATE RESIDENTS IN THE GREATER WATERBURY COMMUNITY ABOUT PERTINENT HEALTH AND WELLNESS ISSUES. THIS PAST YEAR, THE HEART CENTER CONDUCTED A SERIES OF HEALTH FAIRS AND VARIOUS HEALTH AND WELLNESS EDUCATION SESSIONS, INCLUDING "HEALTH SCREENINGS," WHICH PROVIDES PATIENTS WITH COMPLIMENTARY BLOOD PRESSURE SCREENINGS AND HEALTH AWARENESS EDUCATION. THROUGH COLLABORATIVE EFFORT, THE HEART CENTER OF GREATER WATERBURY AND SAINT MARY'S HOSPITAL DEVOTED A TOTAL OF 28 HOURS TO THE SCREENING PROCESS. A NEW PROGRAM CALLED "SMOKING CESSATION" WAS ALSO DEVELOPED DURING THE FISCAL YEAR.

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THE SERIES HELPS OUR RESIDENTS KICK THE HABIT.

FAMILY BIRTHING CENTER - PROVIDING A CHILD-CENTERED FOCUS, WATERBURY HOSPITAL'S FAMILY BIRTHING CENTER OFFERS EXPECTANT PARENTS A VARIETY OF CLASSES INCLUDING: BREAST FEEDING, CHILDBIRTH WEEKEND WORKSHOP, AND CHILDBIRTH PREPARATION, WHICH INCLUDES LAMAZE IN ADDITION TO EXERCISING BREATHING AND RELAXATION TECHNIQUES. THE DEPARTMENT IS EXPECTING THE RETURN OF THE INFANT CARE CLASS BY THE END OF FY 2015. THE FAMILY BIRTHING CENTER ALSO SUGGESTED PLANS OF RESTRUCTURING THE WEBSITE TO BE MORE USER FRIENDLY AND ENGAGING.

THANK GOD I'M FEMALE - FOR THE PAST 20 YEARS, WATERBURY HOSPITAL'S "THANK GOD I'M FEMALE" HAS SERVED AS AN ANNUAL WOMEN'S WELLNESS FORUM THAT FEATURES 40 EDUCATIONAL BOOTHS AND HEALTH-RELATED GIVEAWAYS. THE ULTIMATE GOAL OF THE FORUM IS TO EDUCATE ATTENDEES ABOUT STRESS, MENTAL WELL-BEING, HEART HEALTH, DIET, OSTEOPOROSIS AND BONE HEALTH, CHANGE OF LIFE, AND MORE. IN 2014, OVER 500 AREA RESIDENTS ATTENDED THE EVENT.

EVERGREEN 50 CLUB - WATERBURY HOSPITAL'S EVERGREEN 50 CLUB IS AN ORGANIZATION COMPRISED OF OVER 15,000 MEMBERS OVER THE AGE OF 50. THE CLUB OFFERS WELLNESS PROGRAMMING, MEDICARE COUNSELING, AND HEALTH EDUCATION PRESENTATIONS ON A VARIETY OF TOPICS ARE PRESENTED BY HEALTH CARE PROFESSIONALS. PRESENTATION TOPICS INCLUDE: HOLISTIC HEALTH, VARICOSE VEIN TREATMENT, HEART DISEASE, SUMMER SKIN CARE, WEIGHT LOSS, BLOOD PRESSURE, BLADDER SCREENINGS, JOINT CARE AND REPLACEMENT, AND RESOLVING ADVERSE OUTCOMES WITH PATIENTS AND FAMILIES. ANNUALLY, THE EVERGREEN 50 CLUB HOSTS A HEALTH FAIR FOR ITS MEMBERS, WHICH PROVIDES FREE FLU SHOTS AND HEALTHCARE SCREENINGS.

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WATERBURY HOSPITAL INFECTIOUS DISEASE CLINIC (WHIC) -

CURRENT SERVICES: THE WHIC OFFERS A COMPREHENSIVE "ONE-STOP SHOPPING" MODEL THAT PROVIDES PATIENTS WITH ON-SITE PRIMARY AND SPECIALTY SERVICES, MEDICAL CASE MANAGEMENT, INDIVIDUALIZED MEDICATION ADHERENCE SERVICES, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, NUTRITION COUNSELING, INDIVIDUALIZED HIV EDUCATION, LABORATORY TESTING, AND RADIOLOGY SERVICES. WHIC'S PROVIDERS INCLUDE THREE BOARD-CERTIFIED/BOARD-ELIGIBLE INFECTIOUS DISEASE SPECIALISTS AS WELL AS AN ADVANCED PRACTITIONER NURSE AND A REGISTERED DIETICIAN, ALL WITH EXPERTISE IN THE MANAGEMENT OF PATIENTS WITH HIV/AIDS. IN FY 2014, WHIC SERVED AROUND 500 PEOPLE LIVING WITH HIV/AIDS (PLWHA).

WHIC'S STAFF MEMBERS ACTIVELY PARTICIPATE IN STATEWIDE AND AREA COLLABORATIVE, SUCH AS THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC) AND THE RYAN WHITE PART A PLANNING COUNCIL, AND WHIC FACILITATES THE GREATER WATERBURY HIV CONSORTIUM. WHIC HAS A VERY ACTIVE CONSUMER ADVISORY GROUP (CAG), WHICH ORGANIZES SOCIAL AND TESTING EVENTS FOR THE COMMUNITY AND FACILITATES THE WATERBURY HOSPITAL PHOTOGRAPHY GROUP.

FORGING COMMUNITY PARTNERSHIPS: SINCE 2009, THE WHIC HAS SERVED AS THE LEAD AGENCY FOR RYAN WHITE PART A FEDERAL FUNDING REGION 2 OF THE NEW HAVEN/FAIRFIELD ELIGIBLE METROPOLITAN AREA. THE WHIC WAS CHOSEN AS LEAD AGENCY BY THE CONSENSUS OF OTHER LOCAL RYAN WHITE PART A AGENCIES DUE TO ITS EXPERTISE IN PATIENT CARE AND FISCAL MANAGEMENT. AS THE LEAD AGENCY, THE WHIC HAS FORMED LONGSTANDING PARTNERSHIPS WITH STAYWELL HEALTH CENTER, INC., NEW OPPORTUNITIES, INC., RECOVERY NETWORK OF PROGRAMS, INC., AND CONNECTICUT COUNSELING CENTERS, INC., ALL OF WHOM

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WORK ALONGSIDE THE WHIC TO PROVIDE PATIENTS IN THE REGION WITH:

- PRIMARY HIV CARE
- MEDICAL CASE MANAGEMENT
- ORAL HEALTH CARE
- INPATIENT AND OUTPATIENT SUBSTANCE ABUSE TREATMENT
- HEALTH INSURANCE ASSISTANCE
- MENTAL HEALTH
- EARLY INTERVENTION SERVICES
- HOUSING ASSISTANCE
- EMERGENCY FINANCIAL ASSISTANCE
- MEDICAL TRANSPORTATION
- FOOD PANTRY

IN JUNE 2014, WHIC COLLABORATED WITH THE WATERBURY HEALTH DEPARTMENT, GRACE BAPTIST CHURCH, AND OTHER AREA AIDS SERVICE ORGANIZATIONS, TO ORGANIZE THE WATERBURY AIDS WALK AND RAISE AWARENESS ABOUT HIV/AIDS TREATMENT AND TESTING IN WATERBURY. OVER 200 RESIDENTS PARTICIPATED IN THE EVENT.

RESHAPING HIV TESTING STATEWIDE: SINCE 2008, WATERBURY HOSPITAL (WH) HAS BEEN AT THE FOREFRONT OF DEVELOPING AND IMPLEMENTING SYSTEMS TO ROUTINIZE HIV SCREENING IN ORDER TO IDENTIFY INDIVIDUALS UNAWARE OF THEIR DIAGNOSIS. SINCE 2012, PATIENTS VISITING WH'S EMERGENCY DEPARTMENT RECEIVED WRITTEN NOTIFICATION THAT THEY MAY BE SCREENED FOR HIV UNLESS THEY ELECT TO OPT-OUT. IN ADDITION, ALLIANCE MEDICAL GROUP OFFICES HAVE BEEN PROVIDED TOOLS THAT INCORPORATE ROUTINE HIV SCREENING INTO THEIR PRACTICE. IN THE NEAR FUTURE, WH PLANS TO LAUNCH AN AUTOMATED SYSTEM TO ENSURE THAT ALL PATIENTS VISITING THE WH CAMPUS ARE

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AWARE OF THEIR HIV STATUS. NEWLY DIAGNOSED INDIVIDUALS WILL ALSO BE FAMILIARIZED WITH AVAILABLE TREATMENT OPTIONS AND CARE AT THE WATERBURY HOSPITAL INFECTIOUS DISEASE AND TRAVEL CLINIC.

ENGAGING PATIENTS: IN 2009, THE WHIC ESTABLISHED ITS PEER ADVOCATE PROGRAM. THREE PATIENTS FROM THE CLINIC SERVE AS THE PEER ADVOCATES, WHO WORK WITH CLIENTS AT THE CLINIC AND USE A SOCIAL NETWORKS STRATEGY TO BRING DIFFICULT-TO-REACH CLIENTS IN FOR TESTING AND/OR CARE; THEY HAVE TRAVELED TO HIGH-RISK NEIGHBORHOODS ON THE WATERBURY HEALTH DEPARTMENT'S COMMUNITY HEALTH VAN TO OFFER COUNSELING AND TESTING AND HAVE PARTICIPATED IN AIDS AWARENESS DAYS TO FACILITATE THE LINKAGE OF NEWLY DIAGNOSED PATIENTS TO PRIMARY CARE. PEER ADVOCATES PARTICIPATE IN THE WHIC'S CARE TEAM AND CONTINUUM MEETINGS TO KEEP PROVIDERS AND LOCAL PARTNERS AWARE OF THE PATIENTS' ACTIVITIES AND NEEDS.

THE WHIC OFFERS ITS PATIENTS NATIONALLY-RECOGNIZED PEER AND SUPPORT PROGRAMS, INCLUDING ITS PROJECT PHOTOGRAPHY, WHICH WAS ESTABLISHED IN 2007 TO ENCOURAGE NON-COMPLIANT HIV/AIDS PATIENTS IN THE GREATER WATERBURY AREA TO BECOME MORE PROACTIVE IN THE SELF-MANAGEMENT OF THEIR DISEASE. PROJECT PHOTOGRAPHY HAS POSITIVELY TRANSFORMED ITS PARTICIPANT'S SELF-ESTEEM AND CONFIDENCE. PATIENT PROJECTS HAVE INCLUDED: (1) ENROLLING IN PHOTOGRAPHY CLASSES AT NAUGATUCK VALLEY COMMUNITY COLLEGE, (2) TAKING FIELD TRIPS TO BOSTON AND RHODE ISLAND, (3) DONATING FRAMED PHOTOGRAPHS TO THE HOSPITAL'S ANNUAL FUNDRAISING GALA, (4) PRODUCING HOLIDAY GREETING CARDS FOR THE ID CLINIC, (5) CREATING TEAM PORTRAITS AT THE HOSPITAL'S FUNDRAISING GOLF TOURNAMENT, AND (6) CONSTRUCTING PHOTOGRAPHY EXHIBITS AT THE HOSPITAL ON THE FIRST FLOOR AND IN THE POMEROY; ACCOMPLISHED BY 9 PHOTOGRAPHY STUDENTS FROM

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THE PEACH PROGRAM AND THE SUMMER BRIDGE PROGRAM.

THE FOOD FOR LIFE PROGRAM IS AN INNOVATIVE PROGRAM RECENTLY ESTABLISHED BY WHIC IN COLLABORATION WITH THE WATERBURY YMCA. THIS PROVIDES ACCESS TO FRESH FRUITS AND VEGETABLES AND ENROLLMENT IN EXERCISE PROGRAMS TO QUALIFIED PATIENTS AT NO COST. THE WHIC OFFERS A FITNESS CLASS MONTHLY AND YOGA MONTHLY AS WELL TO PATIENTS, AND NUTRITION, HEALTH, WELLNESS SUPPORT GROUP BIWEEKLY TO ENGAGE IN POSITIVE ACTIVITIES.

CATEGORY B: HEALTH PROFESSIONS EDUCATION

TOTAL BENEFIT: $9,670,648

TOTAL PERSONS SERVED: 1,689

SINCE IT FIRST AFFILIATED WITH THE YALE UNIVERSITY SCHOOL OF MEDICINE IN 1973, WATERBURY HOSPITAL HAS SERVED AS THE CLINICAL TRAINING SITE FOR THOUSANDS OF MEDICAL PROFESSIONALS IN TRAINING. DURING FY 2014, STUDENTS COMPLETED CLINICAL ROTATIONS, INTERNSHIPS, AND SHADOWING EXPERIENCES AT WATERBURY HOSPITAL.

KEY PROGRAMS:

WATERBURY HOSPITAL INTERNAL MEDICINE RESIDENCY PROGRAM -

IN 2014, TWENTY-FOUR RESIDENTS WERE ENROLLED IN THIS PROGRAM. THE RESIDENCY PROGRAM IS SPONSORED BY YALE-NEW HAVEN HOSPITAL AND AFFILIATED WITH YALE UNIVERSITY.

ACTIVITIES INCLUDE:

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- PARTICIPATION IN RESEARCH DAYS AT YALE AND WATERBURY HOSPITAL/SAINT MARY'S HOSPITAL

- HOME AND OFFICE VISITS FOR CLINIC PATIENTS

- EDUCATIONAL SEMINARS HELD AT WATERBURY HOSPITAL AND YALE UNIVERSITY.

AT WATERBURY HOSPITAL, WE SEEK TO TRAIN PHYSICIANS WHO DESIRE A GENERALIST BACKGROUND TO THEIR CAREERS IN MEDICINE. THIS PROGRAM IS UNIQUE IN THAT IT PROVIDES THE MEDICAL RESIDENTS THE OPPORTUNITY TO WORK EACH YEAR AT WATERBURY HOSPITAL AND OUTPATIENT PRACTICE SITES THAT INCLUDE PRIVATE PRACTICE OFFICES AND COMMUNITY HEALTH CENTERS. OUR GRADUATES ARE HIGHLY SOUGHT AFTER BY PRIVATE PRACTICE OFFICES, HOSPITALIST PROGRAMS, AND FELLOWSHIP PROGRAMS THROUGHOUT THE COUNTRY.

OTHER RESIDENCY PROGRAMS -

WATERBURY HOSPITAL ALSO HAS A SURGERY RESIDENCY PROGRAM. THE PROGRAM IS AFFILIATED WITH YALE UNIVERSITY, UNIVERSITY OF CONNECTICUT MEDICAL CENTER, AND QUINNIPIAC UNIVERSITY SCHOOL OF MEDICINE. TWELVE RESIDENTS WERE ENROLLED IN 2014. THIS PROGRAM PROVIDES A FULL SPECTRUM OF SURGICAL EXPERIENCES FOR THE HOSPITAL'S RESIDENTS. GENERAL SURGERY AND MEDICINE TRAINING PROGRAMS INCLUDES ACCESS TO GENERAL SURGERY, ENT, UROLOGY, PLASTICS, GYN, NEUROSURGERY AN ORTHOPEDIC CASES.

WATERBURY HOSPITAL HAS A PHARMACY RESIDENCY PROGRAM. TWO STUDENTS ARE ENROLLED IN THE PHARMACY RESIDENCY PROGRAM. WATERBURY HOSPITAL'S PGY-1 PROGRAM IS ACCREDITED BY THE AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS (ASHP). TWO RESIDENT POSITIONS WILL BE AVAILABLE EACH YEAR. THE MISSION OF THE PHARMACY RESIDENCY PROGRAM IS TO BE CLINICALLY

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FOCUSED AND TO SHARE RESPONSIBILITY FOR THE OPTIMAL OUTCOME OF PATIENT DRUG THERAPIES. 1-YEAR OF CONCENTRATED TRAINING IN ALL ASPECTS OF PHARMACY PRACTICE IS PROVIDED IN ADDITION TO LEARNING ACTIVITY ROTATIONS THAT ACCOMMODATE THE RESIDENT'S PREVIOUS EXPERIENCES AND CURRENT GOALS. ROTATIONS INCLUDED ARE:

- PHARMACY OPERATIONS (FOUR WEEKS)
- INTERNAL MEDICINE (EIGHT WEEKS)
- CRITICAL CARE (EIGHT WEEKS)
- EMERGENCY MEDICINE (SIX WEEKS)
- PSYCHIATRY (FOUR WEEKS)
- PHARMACY ADMINISTRATION (SIX WEEKS)
- PAIN MANAGEMENT (FOUR WEEKS)
- PHARMACY INFORMATICS (FOUR WEEKS)
- AMBULATORY CARE (LONGITUDINAL)

THIS PROGRAM SATISFIES THE ASHP PGY-1 REQUIRED OUTCOMES.

STUDENT NURSE INTERN PROGRAM (SNI) -

THE SNI PROGRAM IS AVAILABLE FOR NURSING STUDENTS ENTERING THEIR SENIOR YEAR. THE PROGRAM PROVIDES THESE STUDENT NURSES WITH SHADOWING OPPORTUNITIES SO THEY CAN APPLY THEIR CONTENT KNOWLEDGE TO AUTHENTIC PATIENT CARE SITUATIONS. STAFF RNS SERVE AS THE STUDENTS' MENTORS AS THE STUDENTS ACCOMPANY THEM ON THEIR MEDICAL ROUNDS. THE GOALS OF THE PROGRAM ARE: (1) TO PROVIDE THE STUDENT NURSES WITH THE KNOWLEDGE AND SKILLS NECESSARY TO PASS THE NCLEX EXAM AND (2) TO SOCIALIZE THE STUDENT NURSE IN AN ATTEMPT TO DECREASE THE STRESS OF ASSIMILATING INTO

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THE HOSPITAL'S WORK ENVIRONMENT, SHOULD THEY BE HIRED AS GRADUATE NURSES AT WATERBURY HOSPITAL.

PHYSICIAN'S ASSISTANT (PA) STUDENTS -

P.A. STUDENTS FROM QUINNIPIAC UNIVERSITY COMPLETED CLINICAL ROUNDS IN SEVERAL DEPARTMENTS AROUND THE HOSPITAL, INCLUDING THE OPERATING ROOM, EMERGENCY DEPARTMENT, BEHAVIORAL HEALTH, AND RADIOLOGY. THE EXPERIENCE IS DESIGNED FOR THE STUDENT TO LEARN TO APPLY THE KNOWLEDGE GAINED FROM DIDACTIC COURSE WORK IN MEDICINE, SURGERY, AND THE BASIC AND BEHAVIORAL SCIENCES INTO THE CLINICAL ARENA RESULTING IN THE ABILITY TO SUCCESSFULLY MANAGE PATIENTS IN A THOROUGH AND COMPREHENSIVE MANNER. THE PRIMARY GOAL OF CLINICAL ROTATIONS IS TO EXPOSE THE STUDENT TO PATIENTS OF ALL AGES, PATIENTS IN A VARIETY OF DIFFERENT SETTINGS, AND PATIENTS WITH A BROAD RANGE OF MEDICAL, SURGICAL, AND PSYCHOSOCIAL PROBLEMS.

THE P.A. STUDENTS PARTICIPATE IN:

- HISTORY TAKING
- EXAMINING THE PATIENT
- ASSISTING IN AND/OR PERFORMING DIAGNOSTIC TESTING
- ASSISTING IN AND/OR PERFORMING THERAPEUTIC TASKS
- ORAL PRESENTATIONS
- MEDICAL DOCUMENTATION OF THE PATIENT ENCOUNTER
- FORMULATING A DIFFERENTIAL DIAGNOSIS AND PROBLEM LIST
- FORMULATING A TREATMENT PLAN
- COUNSELING OF PATIENTS REGARDING MEDICATION, DIET, AND LIFESTYLE CHANGES SUCH AS SMOKING CESSATION, EXERCISE, AND WELL-BEING.

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RADIOLOGY STUDENTS FROM NVCC -

THE NAUGATUCK VALLEY COMMUNITY COLLEGE (NVCC) RADIOLOGY STUDENTS ARE INVOLVED WITH MANY ACTIVITIES WHILE ASSIGNED TO WATERBURY HOSPITAL. UNDER THE SUPERVISION OF A NVCC CLINICAL INSTRUCTOR AND HOSPITAL RADIOLOGIC TECHNOLOGISTS, THE STUDENTS ARE ASSIGNED TO THE VARIOUS RADIOGRAPHIC SUITES AND MODALITIES. DURING THEIR ASSIGNMENT, STUDENTS ARE PERFORMING OR ASSISTING WITH RADIOGRAPHIC PROCEDURES, INCLUDING CHEST X-RAYS, SKELETAL EXAMS, FLUOROSCOPIC PROCEDURES, MOBILE X-RAYS IN THE VARIOUS PATIENT UNITS, AND SURGICAL CASES. THE STUDENTS ALSO INCREASE THE NUMBER OF INDIVIDUALS AVAILABLE IN THE DEPARTMENT TO ASSIST IN MOVING AND TRANSPORTING PATIENTS AS WELL AS CHAPERONING SENSITIVE EXAMS. IN ADDITION TO THE DIAGNOSTIC RADIOLOGY THE STUDENTS ARE ASSIGNED TO EXPERIENCES IN INTERVENTIONAL RADIOLOGY, CT, MRI, NUCLEAR MEDICINE, AND ULTRASOUND. STUDENTS WORK IN THESE MODALITIES UNDER THE DIRECT SUPERVISION OF THE HOSPITAL STAFF.

WATERBURY HOSPITAL'S AFFILIATION WITH NVCC AS A CLINICAL SITE FOR STUDENTS HAS MANY BENEFITS. PERHAPS THE SINGLE MOST IMPORTANT BENEFIT IS THE HOSPITAL HAS A CONTINUOUS STREAM OF POTENTIAL RADIOLOGY EMPLOYEES. STUDENTS ARE IN THE PROGRAM FOR 22 MONTHS AND IN THAT TIME BECOME VERY FAMILIAR WITH THE HOSPITAL EQUIPMENT, ROUTINES, PERSONAL, AND MISSION. THIS PROVIDES WATERBURY HOSPITAL WITH NEW EMPLOYEES WHO HAVE A STRONG SKILL SET AND PROVEN DEDICATION TO THE HOSPITAL COMMUNITY.

CATEGORY D: RESEARCH

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TOTAL BENEFIT: $5,580

TOTAL PERSON SERVED: 17

DURING 2013-2014, WATERBURY HOSPITAL PARTICIPATED IN SEVERAL CLINICAL TRIALS THAT BENEFITED RESIDENTS IN GREATER WATERBURY. THESE TRIALS INCLUDED: THE BIOMARKERS STUDY, WHICH EXPLORED THE IDENTIFICATION OF BIOMARKERS FOR PREDICTION OF RESPONSE TO PREOPERATIVE CHEMORADIOTHERAPY IN PATIENTS WITH RECTAL CANCER; THE ROCKING CHAIR STUDY, WHICH INVESTIGATED ROCKING CHAIR SINGLE WAVE MOTION INTERVENTION FOR POST-SURGICAL PATIENT CARE; THE INFECTIVE ENDOCARDITIS STUDY RUN IN COLLABORATION WITH DUKE UNIVERSITY, WHICH ENROLLS PATIENTS EITHER DIAGNOSED OR PRESENTING SYMPTOMS OF INVECTIVE ENDOCARDITIS FOR A PROSPECTIVE DATA COLLECTION STUDY; AND THE FECAL TRANSPLANT STUDY, WHICH ENROLLS PATIENTS WITH RESISTANT CLOSTRIDIUM DIFFICILE COLITIS WHO HAVE HAD 2 OR MORE RELAPSES OF COLITIS IN SPITE OF ANTIBIOTIC THERAPY.

CATEGORY E: FINANCIAL & IN-KIND CONTRIBUTIONS

TOTAL BENEFIT: $108,982

TOTAL PERSONS SERVED: 112,275

WATERBURY HOSPITAL CONTINUES TO PROVIDE FINANCIAL AND IN-KIND CONTRIBUTIONS TO MEMBERS OF OUR COMMUNITY. FROM UNITED WAY DONATIONS FROM HOSPITAL EMPLOYEES TO FREE PARKING FOR PATIENTS, WATERBURY HOSPITAL PROVIDED $30,705.00 WORTH OF FINANCIAL AND IN-KIND SUPPORT DURING 2014. LOCAL AGENCIES RECEIVING DONATIONS INCLUDED:

- EASTER SEALS
- HOMELESS CONNECT
- MATTATUCK MUSEUM

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- PALACE THEATER

- UNITED WAY OF GREATER WATERBURY

- VNA HEALTH AT HOME

- WATERBURY SYMPHONY ORCHESTRA

- WATERBURY REGIONAL CHAMBER

CATEGORY F: COMMUNITY BUILDING ACTIVITIES

TOTAL BENEFIT: $274,171

TOTAL PERSONS SERVED: 12,813

AS A LEADER IN THE DELIVERY OF HEALTHCARE SERVICES IN THE GREATER WATERBURY AREA, WATERBURY HOSPITAL (WH) IS COMMITTED TO STRENGTHENING THE WELFARE AND AWARENESS OF THE CITIZENS WITHIN ITS COMMUNITY. FROM STRENGTHENING THE CAREER PATHS OF WATERBURY AREA YOUTH; TO SUPPORTING THE UNINSURED AND UNDERINSURED THROUGH THE WATERBURY HEALTH ACCESS PROGRAM AND; PROVIDING TRANSPORT TO AND FROM MEDICAL APPOINTMENTS; WATERBURY HOSPITAL IS REMOVING THE BARRIERS TO QUALITY HEALTH CARE FOR ALL AND REMAINS FIRM IN ITS COMMITMENT TO A HEALTHIER, STRONGER, AND MORE PRODUCTIVE COMMUNITY.

KEY PROGRAMS:

YOUTH PIPELINE INITIATIVES:

THE WATERBURY HOSPITAL YOUTH PIPELINE INITIATIVES WERE ESTABLISHED IN 2001 AS A PARTNERSHIP BETWEEN WATERBURY HOSPITAL AND WATERBURY PUBLIC SCHOOLS. THE MISSION OF THE PROGRAM IS: "TO CLOSE THE ACHIEVEMENT GAP FOR MINORITY AND ECONOMICALLY DISADVANTAGED STUDENTS IN WATERBURY SO

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THEY CAN MATRICULATE AND COMPETE NATIONALLY FOR PLACEMENT IN POST-SECONDARY EDUCATION PROGRAMS IN PREPARATION FOR HEALTH CAREERS". WATERBURY HOSPITAL IS COMMITTED TO ENHANCING AND ENRICHING THE ACADEMIC OPPORTUNITIES AND PERSONAL JOURNEYS OF OUR YOUTH, WHO ARE THE EMERGING WORKFORCE OF TOMORROW. TO THIS END, DURING 2014, WATERBURY HOSPITAL PROVIDED 129 STUDENTS AND PARENTS IN GREATER WATERBURY WITH UNIQUE EDUCATIONAL PROGRAMS THAT WILL ENHANCE THE OVERALL WELFARE OF OUR COMMUNITY.

THE WH YOUTH PIPELINE INITIATIVES HAD SIX FOCUS AREAS DURING FY 2014, INCLUDING:

- PARENT LEADERSHIP TRAINING INSTITUTE (PLTI) - IN 2014, SIX INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED WATERBURY'S PLTI, A 20-WEEK CURRICULUM TEACHING LEADERSHIP AND ADVOCACY SKILLS, AS WELL AS INDIVIDUAL COMMUNITY PROJECT PLANNING. PLTI'S CORE MISSION IS TO IMPART LEADERSHIP AND ADVOCACY SKILLS TO PARENTS WHILE SIMULTANEOUSLY EDUCATING THEM ABOUT VOLUNTEERISM, CIVIC LIFE, AND THE PROCESS BY WHICH STATE AND LOCAL GOVERNMENTS ENACT AND CHANGE LAWS. EACH PARTICIPANT COMPLETES AND IMPLEMENTS A COMMUNITY PROJECT; EXAMPLES OF PROJECTS FROM 2014 INCLUDE: A "JUJI'S SENSORY FRIENDLY FILMS" PROGRAM-TO CREATE A SAFE AND ACCEPTING ENVIRONMENT FOR CHILDREN ON THE AUTISM SPECTRUM TO ATTEND FILMS AT THE MOVIE THEATER ON A MONTHLY BASIS AND "PADRE LATINOS" - A SUPPORT GROUP FOR SINGLE FATHERS TO LEARN KNOWLEDGE AND INFORMATION THROUGH THE LIFE EXPERIENCES OF THEIR PEERS.

- PARENTS SUPPORTING EDUCATIONAL EXCELLENCE (PSEE) - IN 2014, SEVENTEEN INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED

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WATERBURY'S PSEE, A 12-WEEK CURRICULUM CO-CREATED BY THE CONNECTICUT CENTER FOR SCHOOL CHANGE AND THE CONNECTICUT COMMISSION ON CHILDREN FOR PARENTS (DEFINED BROADLY AS PARENTS, GUARDIANS, FAMILY MEMBERS AND GRANDPARENTS) TO INSTILL LEADERSHIP SKILLS IN EDUCATION AND TO FACILITATE PARTNERSHIPS BETWEEN SCHOOL STAFF AND PARENTS TO IMPROVE STUDENT LEARNING.

- UCONN PEOPLE EMPOWERING PEOPLE (PEP) OFFERED IN SPANISH AND ALBANIAN - BOTH FREE INAUGURAL PROGRAMS WERE HELD IN 2014. THE PROGRAMS INCLUDED A 10-WEEK PARENT LEADERSHIP AND ADVOCACY REGIMEN THROUGH WHICH 9 PARTICIPANTS SUCCESSFULLY COMPLETED THE ALBANIAN PORTION OF THE PEP COURSE AND 21 PARTICIPANTS COMPLETED THE SPANISH PORTION OF THE PEP COURSE. UCONN PEP IS A PERSONAL, FAMILY AND LEADERSHIP DEVELOPMENT PROGRAM WITH A STRONG COMMUNITY FOCUS. PEP IS DESIGNED TO BUILD ON THE UNIQUE STRENGTHS AND LIFE EXPERIENCES OF PARTICIPANTS AND EMPHASIZES THE CONNECTION BETWEEN INDIVIDUAL AND COMMUNITY ACTION. BOTH UCONN PEP PROGRAMS ARE SIGNIFICANT FOR TWO REASONS; IT WAS THE FIRST TIME THAT A UCONN PEP COURSE HAS BEEN OFFERED IN BOTH ALBANIAN AND SPANISH AT WATERBURY HOSPITAL. HOWEVER IT IS ALSO THE FIRST TIME AN ALBANIAN AND SPANISH PARENT LEADERSHIP PROGRAM IS OFFERED WITH IN THE STATE OF CONNECTICUT. PARTICIPANTS OF BOTH PROGRAMS WORK INDIVIDUALLY OR COLLABORATIVELY TO CREATE A COMMUNITY PROJECT WHICH IS COMPLETED AS THE CONCLUDING PORTION OF THE PROGRAM

- WH SUMMER BRIDGE PROGRAM - DURING THE SUMMER OF 2014, TWENTY-EIGHT STUDENTS FROM WATERBURY, GRADES 6-11, PARTICIPATED IN THE WH SUMMER BRIDGE PROGRAM. 100% OF MEALS WERE SECURED FOR THE PROGRAM FROM CITY OF WATERBURY SUMMER FOOD PROGRAM.

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STUDENTS COMPLETED THE FOLLOWING MODULES:

- 12 HOURS OF MATH (PRE- ALGEBRA, ALGEBRA II, GEOMETRY AND CALCULUS) REVIEW SESSIONS

- 20 HOURS OF SAT WRITING AND VOCABULARY

- 18 HOURS OF PHOTOVOICE PROJECT, STUDENTS WERE INSTRUCTED ON PHOTOGRAPHY TECHNIQUES, COMPOSITION, AND EDITING USING ADOBE PHOTOSHOP SOFTWARE AND SLR CAMERAS

- 6 HOURS OF ESSAY WRITING

- 11 HOURS OF POETRY INSTRUCTION AND PARTICIPATION IN THE SECOND ANNUAL WH POETRY SLAM

- 8 HOURS OF JOB SHADOWING SESSIONS IN THE FOLLOWING DEPARTMENTS: NURSING, HEALTH INFORMATION MANAGEMENT, HUMAN RESOURCES, RESPIRATORY THERAPY, WATERBURY HEALTH ACCESS PROGRAM, MORRISON FOOD SERVICES & NUTRITION, FINANCE, INFECTIOUS DISEASES CLINIC, LAB, PHARMACY, CENTRAL SCHEDULING, PLANT ENGINEERING, HAROLD LEEVER REGIONAL CANCER CENTER, AMERICAN MEDICAL REPONSES, AND CLINICAL EDUCATION, WHICH INCLUDED PARTICIPATING IN CLASSES SPONSORED BY THE AMERICAN RED CROSS (CPR AND BABYSITTING).

- CPR & AMERICAN RED CROSS CERTIFIED BABYSITTING COURSE.

- 2 HOURS OF MS OFFICE COMPUTER SESSIONS

- 6 HOUR SCIENCE MODULE AT STONE ACADEMY

- 2 FULL-DAY FIELD TRIPS COMPLETED: ONE TO YALE UNIVERSITY FOR AN ADMISSIONS INFO SESSION AND CAMPUS TOUR AND ONE TO HAMMONASSET STATE PARK INCLUDING THREE EDUCATIONAL SESSIONS AT MEIGS POINT NATURE CENTER

- 2 HOURS OF COLLEGE ADMISSIONS PRESENTATIONS COMPLETED BY UCONN WATERBURY & NAUGATUCK VALLEY COMMUNITY COLLEGE

- 1 HOUR OF INDIVIDUAL ACADEMIC ADVISING

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- 2 HOURS OF HR ORIENTATION & SOFT SKILLS TRAINING

- 10 HOURS OF SOCIAL DETERMINANTS OF HEALTH DOCUMENTARIES AND ACTIVE DISCUSSIONS WITH THE WATERBURY DEPARTMENT OF PUBLIC HEALTH

- PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) - SINCE ITS INCEPTION IN 2004, WATERBURY HOSPITAL'S PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) PROGRAM HAS ENGAGED ADMINISTRATORS, TEACHERS, AND STUDENTS FROM MIDDLE SCHOOLS IN GREATER WATERBURY TO ADDRESS PROJECTED SHORTAGES OF HEALTHCARE WORKERS AND TO CLOSE THE ACHIEVEMENT GAP FOR STUDENTS IN WATERBURY PUBLIC SCHOOLS. THROUGH THE PEACH PROGRAM, STUDENTS ENGAGE WITH HEALTHCARE WORKERS IN A NON-EMERGENCY SETTING AND ARE INFORMED OF THE VARIETY OF HEALTHCARE CAREER OPPORTUNITIES AVAILABLE IN OUR COMMUNITY. ANNUALLY, WATERBURY HOSPITAL ALSO OFFERS ITS PEACH SPRING BREAK EXPLORATION CAMP, THIS YEAR 48 MIDDLE SCHOOL STUDENTS FROM WATERBURY TOOK PART IN: SHADOWING AND HANDS-ON LEARNING ACTIVITIES AT THE HOSPITAL; CPR CERTIFICATION; AND EDUCATIONAL SESSIONS AT THE MYSTIC AQUARIUM.

SUPPORT GROUPS - DURING 2014, WATERBURY HOSPITAL HOSTED SEVERAL SUPPORT GROUPS FOR ITS PATIENTS AND THEIR FAMILIES, INCLUDING:

- BEHAVIORAL HEALTH'S PARENT AND SIBLING SUPPORT GROUP, WHICH OFFERS EMOTIONAL ASSISTANCE TO FAMILIES WHO HAVE CHILDREN IN TREATMENT; AND

- ALCOHOLICS ANONYMOUS, SERVES OVER 4,000 PEOPLE ANNUALLY, MEETS WEEKLY THROUGHOUT THE YEAR, AND IS COORDINATED BY OUR BEHAVIORAL HEALTH DEPARTMENT.

FORM 990, PART VI, SECTION A, LINE 6:

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GREATER WATERBURY HEALTH NETWORK, INC. IS SOLE MEMBER.

FORM 990, PART VI, SECTION A, LINE 7A:

GREATER WATERBURY HEALTH NETWORK, INC. ELECTS HOSPITAL BOARD.

FORM 990, PART VI, SECTION A, LINE 7B:

GREATER WATERBURY HEALTH NETWORK, INC. HAS RESERVED POWERS FOR HOSPITAL TRANSACTIONS.

FORM 990, PART VI, SECTION B, LINE 11:

THE FORM 990 IS REVIEWED AND APPROVED BY THE ORGANIZATION'S AUDIT COMMITTEE. A COPY OF THE FORM 990 IS THEN MADE AVAILABLE TO EACH BOARD MEMBER BEFORE IT IS FILED.

FORM 990, PART VI, SECTION B, LINE 12C:

THE HOSPITAL COMPLIANCE OFFICER REVIEWS ANNUALLY THE SUBMISSION OF POTENTIAL/ACTUAL CONFLICT DECLARATIONS. THEY ARE ALSO REVIEWED ANNUALLY AT THE BOARD'S COMPLIANCE AND ETHICS COMMITTEE MEETING AND RECOMMENDATIONS FOR ACTION ARE MADE TO THE FULL BOARD AS NECESSARY. ADDITIONALLY, RESPONSES ARE PROFILED, BY MEMBER, FOR EACH COMMITTEE OF THE BOARD/NETWORK, AND DISTRIBUTED AT EACH COMMITTEE MEETING AS A WAY TO PROMOTE TRANSPARENCY. THE COMMITTEE CHAIR AND MEMBERS SHARE RESPONSIBILITY IN IDENTIFYING AND MANAGING THESE DECLARED CONFLICTS OF INTEREST WHEN MAKING BUSINESS DECISIONS ON BEHALF OF THE HOSPITAL.

FORM 990, PART VI, SECTION B, LINE 15:

EXECUTIVE COMPENSATION IS UNDER THE PURVIEW OF THE BOARD OF TRUSTEES. THERE IS A COMPENSATION COMMITTEE AND THEY ALWAYS USE THE

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SERVICES OF AN INDEPENDENT COMPENSATION CONSULTANT WHO USES NATIONAL, STATE AND REGIONAL COMPENSATION SURVEY DATA FOR SIMILAR TAX EXEMPT COMMUNITY HOSPITALS.

FORM 990, PART VI, SECTION C, LINE 19:

FINANCIAL RESULTS ARE MADE AVAILABLE IN THE ANNUAL REPORT TO THE COMMUNITY. GOVERNING DOCUMENTS AND THE CONFLICT OF INTEREST POLICY ARE AVAILABLE UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:

CONSULTING FEES:

PROGRAM SERVICE EXPENSES	377,502.
MANAGEMENT AND GENERAL EXPENSES	1,498,524.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,876,026.

PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	28,088,112.
MANAGEMENT AND GENERAL EXPENSES	9,898,230.
FUNDRAISING EXPENSES	1,599.
TOTAL EXPENSES	37,987,941.

PROFESSIONAL MEDICAL FEES:

PROGRAM SERVICE EXPENSES	10,342,344.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	10,342,344.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	50,206,311.

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FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

INCREASE IN FAIR VALUE OF FUNDS HELD IN TRUST BY OTHERS	1,157,722.
ALLIANCE SUBSIDY	-8,152,669.
PENSION LIABILITY ADJUSTMENT	-841,605.
INTEREST RATE SWAP ADJUSTMENT	217,110.
INCOME FROM WATERBURY GASTROENTEROLGY	-62,801.
TOTAL TO FORM 990, PART XI, LINE 9	-7,682,243.

FORM 990, PART XII, LINE 2C:

THE AUDIT COMMITTEE AND THE BOARD OF DIRECTORS HAS THE RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT. THE AUDIT COMMITTEE MAKES RECOMMENDATIONS TO THE BOARD OF DIRECTORS IN REGARD TO THE SELECTION OF AN INDEPENDENT AUDITOR.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990. ▶ See separate instructions.

▶Information about Schedule R (Form 990) and its instructions is at *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

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Employer identification number

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Part I **Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
CARDIOLOGY ASSOCIATES OF GREATER WATERBURY, LLC - 27-3828899, 455 CHASE PARKWAY, WATERBURY, CT 06708	CARDIOLOGY PRACTICE	CONNECTICUT	-3,143,116.	2,809,298.	THE WATERBURY HOSPITAL

Part II **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
GREATER WATERBURY HEALTH NETWORK, INC. - 22-2572044, 64 ROBBINS STREET, WATERBURY, CT 06721	HEALTH CARE MANAGEMENT	CONNECTICUT	501(C)(3)	11 TYPE 1	N/A		X
GREATER WATERBURY HEALTH SERVICES, INC. - 22-2572042, 64 ROBBINS STREET, WATERBURY, CT 06708	HEALTH SERVICES	CONNECTICUT	501(C)(3)	9	GREATER WATERBURY HEALTH NETWORK, INC.		X
ALLIANCE MEDICAL GROUP, INC. - 26-3520540 1625 STRAITS TURNPIKE, SUITE 211 MIDDLEBURY, CT 06762	HEALTH SERVICES	CONNECTICUT	501(C)(3)	9	THE WATERBURY HOSPITAL	X	

Part III **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
ACCESS REHAB CENTERS, LLC - 06-1527429, 22 TOMPKINS STREET, WATERBURY, CT 06708	THERAPY SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	683,838.	2,736,965.		X	N/A		X	65.00%
GREATER WATERBURY IMAGING CENTER, LLP - 06-1242903, 64 ROBBINS STREET, WATERBURY, CT 06721	IMAGING SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	964,832.	2,008,668.		X	N/A		X	63.64%
IMAGING PARTNERS, LLC - 06-1617047, 134 GRANDVIEW AVENUE, WATERBURY, CT 06708	IMAGING SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	58,240.	365,616.		X	N/A		X	85.00%
WATERBURY GASTROENTEROLOGY CO-MANAGEMENT COMPANY, LLC - 27-2417014, 64 ROBBINS STREET, WATERBURY, CT 06721	MEDICAL SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	62,801.	145,595.		X	N/A		X	45.45%

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a	X	
b Gift, grant, or capital contribution to related organization(s)	1b	X	
c Gift, grant, or capital contribution from related organization(s)	1c		X
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j	X	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	X	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o Sharing of paid employees with related organization(s)	1o		X
p Reimbursement paid to related organization(s) for expenses	1p		X
q Reimbursement paid by related organization(s) for expenses	1q		X
r Other transfer of cash or property to related organization(s)	1r	X	
s Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) ACCESS REHAB CENTERS, LLC	A	69,673.	
(2) ACCESS REHAB CENTERS, LLC	L	1,373,769.	
(3) ALLIANCE MEDICAL GROUP	A	27,071.	
(4) GREATER WATERBURY IMAGING CENTER, LLP	A	105,628.	
(5) GREATER WATERBURY IMAGING CENTER, LLP	L	1,022,900.	
(6) ALLIANCE MEDICAL GROUP	B	60,364.	

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

	(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7)	ALLIANCE MEDICAL GROUP	R	8,152,669.	
(8)				
(9)				
(10)				
(11)				
(12)				
(13)				
(14)				
(15)				
(16)				
(17)				
(18)				
(19)				
(20)				
(21)				
(22)				
(23)				
(24)				

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) NO	(k) Percentage ownership

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS
AND OTHER FINANCIAL INFORMATION

SEPTEMBER 30, 2014 AND 2013

THE WATERBURY HOSPITAL AND SUBSIDIARIES

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MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT

Board of Trustees
The Waterbury Hospital

We have audited the accompanying consolidated financial statements of The Waterbury Hospital, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards re□uire that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors□ judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity□s preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity□s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting polices used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of The Waterbury Hospital as of September 30, 2014 and 2013, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Marcum LLP

Hartford, CT
December 19, 2014

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

SEPTEMBER 30, 2014 AND 2013

	2014	2013
Assets		
Current Assets		
Cash and cash equivalents	$ 31,909,931	$ 23,993,423
Restricted cash	675,000	4,519,908
Short-term investments	507,699	472,637
Patient accounts receivable, less allowance ($9,207,000 in 2014 and $15,022,000 in 2013)	30,793,644	29,441,126
Grants and other receivables	3,843,762	3,702,524
Inventories of supplies	3,913,945	3,581,595
Prepaid insurance and other expenses	1,923,352	1,571,465
Total Current Assets	73,567,333	67,282,678
Other Assets		
Funds held in trust by others	46,117,761	44,960,039
Long-term investments	11,118,017	10,814,695
Board-designated endowment funds	3,315,500	3,193,664
Other receivables	77,952	171,972
Goodwill	1,813,567	1,813,567
CHEFA obligations issue expense, less amortization	243,686	282,676
	62,686,483	61,236,613
Property, plant and equipment:		
Land	287,549	287,549
Buildings and improvements	94,308,166	94,052,332
Equipment	188,064,397	186,912,261
Construction in progress	--	73,654
	282,660,112	281,325,796
Less accumulated depreciation	(246,745,886)	(238,890,019)
	35,914,226	42,435,777
	$ 172,168,042	$ 170,955,068

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS (CONTINUED)

SEPTEMBER 30, 2014 AND 2013

	2014	2013
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	$ 23,322,768	$ 21,578,227
Salaries, wages, payroll taxes and amounts withheld from employees	9,841,900	7,395,011
Due to third-party reimbursement agencies	4,171,981	2,969,391
Current portion of CHEFA obligations	493,776	472,136
Current portion of notes payable and capital lease obligations	461,705	694,549
Due to affiliates	600,116	2,042,951
Total Current Liabilities	38,892,246	35,152,265
Other Noncurrent Liabilities	25,354,977	21,813,507
CHEFA Obligations - less current portion	23,789,744	24,283,520
Notes Payable and Capital Lease Obligations - less current portion	438,984	852,568
Net Assets		
Unrestricted	23,336,473	29,976,833
Temporarily restricted	8,729,527	8,409,794
Permanently restricted	48,909,797	47,752,075
Total Net Assets Excluding Noncontrolling Interests	80,975,797	86,138,702
Noncontrolling Interests	2,716,294	2,714,506
Total Net Assets	83,692,091	88,853,208
	$ 172,168,042	$ 170,955,068

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Unrestricted Revenues		
Net patient service revenues	$248,836,314	$254,713,112
Provision for bad debts	(4,436,817)	(11,366,671)
Net patient service revenues less provision for bad debts	244,399,497	243,346,441
Other operating revenues	4,196,829	5,209,968
Net assets released from restrictions	5,542,491	5,419,591
	254,138,817	253,976,000
Operating Expenses		
Salaries	118,051,397	116,676,000
Employee benefits	29,379,803	30,913,497
Supplies and other	105,737,994	100,247,756
Depreciation	7,860,960	8,821,562
Interest and amortization	1,384,987	1,049,355
	262,415,141	257,708,170
Loss from Operations	(8,276,324)	(3,732,170)
Nonoperating Gains		
Unrestricted gifts and bequests	1,240,261	217,275
Investment income	1,840,688	1,737,423
	3,080,949	1,954,698
Deficiency of Revenues over Expenses Before Changes in Net Unrealized Gains on Investments	(5,195,375)	(1,777,472)
Changes in Net Unrealized Gains on Investments	92,827	268,235
Deficiency of Revenues over Expenses	(5,102,548)	(1,509,237)
Less Excess of Revenues over Expenses Attributable to Noncontrolling Interests	(926,677)	(874,685)
Deficiency of Revenues Over Expenses Attributable to Controlling Interest	(6,029,225)	(2,383,922)

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Unrestricted Net Assets, Controlling Interest		
Deficiency of revenues over expenses	$ (6,029,225)	$ (2,383,922)
Net assets released from restrictions used for purchase of property and equipment	13,360	19,654
Interest rate swap adjustment	217,110	1,209,256
Pension liability adjustments	(841,605)	903,495
Decrease in Unrestricted Net Assets, Controlling Interest	(6,640,360)	(251,517)
Unrestricted Net Assets, Noncontrolling Interest		
Excess of revenues over expenses	926,677	874,685
Distributions and other	(924,889)	(1,307,721)
Increase (Decrease) in Unrestricted Net Assets Noncontrolling Interest	1,788	(433,036)
Temporarily Restricted Net Assets		
Gifts and bequests	453,516	475,360
Income from investments	447,776	497,540
Net realized and unrealized gains on investments	604,989	810,002
Grants	4,369,303	4,420,717
Net assets released from restrictions	(5,555,851)	(5,439,245)
Increase in Temporarily Restricted Net Assets	319,733	764,374
Permanently Restricted Net Assets		
Increase in fair value of funds held in trust by others	1,157,722	2,741,876
Increase in Permanently Restricted Net Assets	1,157,722	2,741,876
(Decrease) Increase in Net Assets	(5,161,117)	2,821,697
Net Assets - Beginning	88,853,208	86,031,511
Net Assets - End	$ 83,692,091	$ 88,853,208

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Cash Flows from Operating Activities and Nonoperating Revenues		
Change in net assets	$ (5,161,117)	$ 2,821,697
Adjustments to reconcile change in net assets to net cash provided by operating activities and nonoperating revenues:		
Provision for bad debts	4,436,817	11,366,671
Depreciation and amortization	7,899,950	8,860,554
Pension liability adjustments	841,605	(903,495)
Distributions to noncontrolling interests	924,889	1,307,721
Net realized and unrealized gains and change in fair value of funds held in trust by others	(1,855,538)	(3,820,113)
Restricted gifts, bequests and income from investments	(901,292)	(972,900)
Change in market value of interest rate swap	(217,110)	(1,209,256)
	5,968,204	17,450,879
Changes in operating working capital other than cash and cash equivalents:		
Patient accounts receivable, net	(5,789,335)	(9,035,821)
Grants and other receivables	(141,238)	(725,020)
Inventories of supplies	(332,350)	(276,516)
Prepaid insurance and other expenses	(351,887)	(77,953)
Accounts payable and accrued expenses	1,744,541	(6,842,414)
Salaries, wages, payroll taxes and amounts withheld from employees	2,446,889	(930,163)
Due to third-party reimbursement agencies	1,202,590	2,368,120
Increase in other noncurrent liabilities	2,916,975	2,073,189
	1,696,185	(13,446,578)
Net Cash Provided by Operating Activities and Nonoperating Revenues	7,664,389	4,004,301

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Cash Flows from Investing Activities		
Decrease (increase) in restricted cash	□ 3,844,908	□ (1,008,510)
Purchases of investments	(23,946,145)	(23,516,332)
Sales of investments	24,183,741	24,199,444
Cash paid to affiliates	(1,442,835)	(956,989)
Other assets	94,020	118,444
Additions to property, plant and e□uipment	(1,339,409)	(2,122,895)
Net Cash Provided by (Used in) Investing Activities	1,394,280	(3,286,838)
Cash Flows from Financing Activities		
Restricted gifts, be□uests and income from investments	901,292	972,900
Distributions to noncontrolling interests	(924,889)	(1,307,721)
Proceeds from issuance of debt	55,580	157,781
Principal payments on debt obligations	(1,174,144)	(1,154,775)
Net Cash Used in Financing Activities	(1,142,161)	(1,331,815)
Net Increase (Decrease) in Cash and Cash Equivalents	7,916,508	(614,352)
Cash and Cash Equivalents - Beginning	23,993,423	24,607,775
Cash and Cash Equivalents - End	□ 31,909,931	□ 23,993,423

Supplemental Cash Flow Information

Cash paid during the year for interest on borrowings was □1,217,495 and □1,224,496 for the years ended September 30, 2014 and 2013, respectively.

The accompanying notes are an integral part of these consolidated financial statements.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION

ORGANIZATION

The Waterbury Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Greater Waterbury Health Network, Inc. (sole member) (the Network or GWHN). The Board of the Hospital, which is appointed by the Network, controls the operations of the Hospital. In addition to the Hospital, the accompanying financial statements include Access Rehab Centers, LLC (Access), Greater Waterbury Imaging Center Limited Partnership (GWIC), Imaging Partners, LLC, Alliance Medical Group, Inc. (AMG) and Cardiology Associates of Greater Waterbury, LLC (CAGW) to the extent of the Hospital's ownership interest in these subsidiaries and affiliated entities.

On October 29, 2012, the Network signed a Letter of Intent to develop a Joint Venture relationship with Vanguard Health Systems, Inc. (Vanguard) of Nashville, TN, a network of for-profit hospitals. Under terms of the proposed Joint Venture, the two organizations would form a Limited Liability Company in which Vanguard would have an 80 percent ownership interest and GWHN would have a 20 percent interest. The Joint Venture would acquire substantially all of the unrestricted assets and assume certain liabilities of the Hospital and GWHN. The Joint Venture would create a taxable, for-profit health system. On October 1, 2013, Tenet Healthcare Corporation (THC) completed its acquisition of Vanguard.

Approval from the State of Connecticut Office of Health Care Access (OHCA), the Office of the Attorney General, and from state and federal antitrust authorities is required.

A public hearing before the Office of the Attorney General and Office of Health Care Access was held on October 15, 2014. The Hospital received on December 1, 2014, proposed decision documents from the Office of the Attorney General and OHCA approving the proposed formation of the Joint Venture with Vanguard subject to certain conditions. Citing the number and restrictive nature of the conditions, Vanguard withdrew the application and on December 11, 2014 has publicly announced its decision not to pursue this transaction.

During November 2010, the Hospital established a limited liability company by the name of Cardiology Associates of Greater Waterbury, LLC to operate a cardiology practice. CAGW acquired the assets of Cardiology Associates of Waterbury (CAW), an unaffiliated entity, that were used by CAW physicians in the performance of their professional services.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

ORGANIZATION (CONTINUED)

The Waterbury Hospital also acquired the assets of CAW that were used by CAW to perform diagnostic ancillary services. The Hospital converted these ancillary services to provider-based services, which are provided at a diagnostic center located near the Hospital. The goodwill recorded on the consolidated balance sheets relates to the purchase of CAW.

During June 2010, the Hospital entered into an arrangement with certain gastroenterology physician-members of the Hospital's medical staff to form Waterbury Gastroenterology Co-Management Company, LLC (GI Co-Management Company), a Connecticut limited liability company. This company was formed as a collaborative effort between the Hospital and the physicians for the purpose of improving the quality and efficiency of the gastroenterology service line at the Hospital. The Hospital's investment of $50,000 in the GI Co-Management Company is included in the Hospital's consolidated financial statements in long-term investments.

The Hospital entered into a members agreement, making it an equal member with St. Mary's Hospital, located in Waterbury, Connecticut, in a joint venture to form The Harold Leever Regional Cancer Center, Inc. (the Cancer Center). The Cancer Center is a Connecticut non-stock corporation exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The purpose of the joint venture is to develop, construct, own and operate the Cancer Center. Both member hospitals transferred the revenue and related expenses of their respective radiation oncology services to the Cancer Center in October 2002. Both member hospitals made working capital advances to the Cancer Center. The Cancer Center is not included in the Hospital's consolidated financial statements. During the year ended September 30, 2014, the Cancer Center provided a $1 million unrestricted grant to the Hospital that is included in unrestricted gifts and bequests in the consolidated statements of operations and changes in net assets.

The Hospital's major accounting policies are as summarized below and in Note 2.

PRINCIPLES OF CONSOLIDATION

The consolidated financial statements include the accounts of the Hospital, its subsidiaries and affiliated entities. Recognition has been given to noncontrolling interests in the affiliates which is reflected as a component of unrestricted net assets. All significant intercompany accounts and transactions are eliminated in consolidation.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated uncollectible accounts receivable for services to patients, and liabilities, including estimated net settlements with third-party reimbursement agencies and professional and pension liabilities, and disclosure of contingent assets and contingent liabilities at the date of the financial statements. Estimates also affect the amounts of revenues and expenses reported during the reporting period. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term. Actual results could differ from those estimates.

RECLASSIFICATIONS

Certain 2013 amounts were reclassified to conform to the 2014 presentation.

REGULATORY MATTERS

The Hospital is required to file annual operating information with OHCA.

TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily restricted net assets are available to provide grant related services, free care, and educational seminars. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity or in funds held in trust by others.

DONOR RESTRICTED GIFTS

Unconditional promises to give cash are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises to give are received. Amortization of the discounts is included in gifts and bequests on the consolidated statements of operations and changes in net assets.

The gifts are reported as either temporarily or permanently restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

CASH AND CASH EQUIVALENTS

The Hospital considers all highly liquid investments with remaining maturities of three months or less at date of purchase to be cash equivalents. Cash and cash equivalents are held at a limited number of financial institutions and at times, the amounts on deposit exceed insured limits.

RESTRICTED CASH

At September 30, 2014, the Hospital had a $4.5 million surety bond with an insurance company to support its self-insured workers compensation program that was collateralized by an investment held by a bank. As of September 30, 2014, there were no borrowings on the surety bond.

At September 30, 2013, the Hospital had letters of credit totaling $4.5 million with banks to support its self-insured workers compensation program that were collateralized by certain investments held by the banks. As of September 30, 2013, there were no borrowings on the letters of credit.

ACCOUNTS RECEIVABLE

Patient accounts receivable result from the health care services provided by the Hospital and its subsidiaries. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts.

The amount of the allowance for doubtful accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See Note 2 for additional information relative to net patient service revenues and third-party payor programs.

INVENTORIES

Inventories are stated at the lower of cost or market. The Hospital values its inventories using the first in first out method.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INVESTMENTS

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) and unrealized gains and losses are included in the deficiency of revenues over expenses unless the income or loss is restricted by donor or law.

Unrealized gains and losses on investments related to permanently restricted net assets and certain temporarily restricted net assets are included in temporarily restricted net assets under State law which allows the Board of Trustees to appropriate as much of the net appreciation of investments as is prudent considering the Hospital's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions. Reference is made to Note 5.

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment are recorded at cost. The Hospital and its subsidiaries provide for depreciation of property, plant and equipment and amortization of assets recorded under capital leases using the straight-line method in amounts sufficient to amortize the cost of the assets over their estimated useful lives which range from 3 to 40 years.

Financial Accounting Standards Board (FASB) ASC 410-20, *Accounting for Asset Retirement Obligations* (ASC 410-20), provides guidance on accounting and reporting for obligations associated with the retirement of tangible long-lived assets and the associated asset retirement costs. Asset retirement obligations include, but are not limited to, certain types of environmental issues which are legally required to be remediated upon an asset's retirement as well as contractually required asset retirement obligations. ASC 410-20 provides clarifying guidance on conditional asset retirement obligations. Conditional asset retirement obligations are obligations whose settlement may be uncertain. ASC 410-20's guidance requires such conditional asset retirement obligations to be estimated and recognized.

Conditional asset retirement obligations of $2,801,923 and $2,684,704 as of September 30, 2014 and 2013, respectively, are recorded in other noncurrent liabilities related to future asbestos remediation. During 2014 and 2013, there were no retirement obligations incurred or settled.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

GOODWILL

Goodwill, which has an indefinite life, is not amortized and is evaluated for impairment at least annually or whenever events or business conditions indicate that the carrying values of such assets may not be fully recoverable.

IMPAIRMENT OF LONG-LIVED ASSETS

The Hospital records impairment losses on long-lived assets used in operations when events and circumstances indicate that the assets might be impaired and the undiscounted cash flows estimated to be generated by those assets are less than the carrying amounts of those assets. There were no impairment losses recorded in 2014 and 2013.

NONOPERATING GAINS

Activities, other than in connection with providing health care services, are considered to be nonoperating. Nonoperating gains consist primarily of income on invested funds, gains and losses on sales of securities, changes in unrestricted unrealized gains and losses and unrestricted gifts and bequests.

DEFICIENCY OF REVENUES OVER EXPENSES

The consolidated statements of operations and changes in net assets include the deficiency of revenues over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from the deficiency of revenues over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), pension liability adjustments, and interest rate swap adjustments.

INCOME TAXES

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Hospital is also exempt from state income taxes. Access, GWIC, CAGW, and Imaging Partners LLC are partnerships. For tax purposes, these partnerships are pass-through entities. Taxation does not occur at the partnership level. Accordingly, no provision for taxes is included. AMG is tax exempt under Section 501 (c)(3) of the Internal Revenue Code.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INCOME TAXES (CONTINUED)

Management has analyzed the tax positions taken and has concluded that as of September 30, 2014, there are no uncertain tax positions taken or expected to be taken in that would require recognition of a liability (or asset) or disclosure in the financial statements. The Hospital is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes the Hospital is no longer subject to income tax examinations prior to 2011.

MEDICAL MALPRACTICE AND WORKERS' COMPENSATION INSURANCE

The Hospital has a policy of self-insuring the deductible portion of its workers' compensation claims. The deductible limit is $750,000 and $500,000 per claim for the years ended September 30, 2014 and 2013, respectively. Management records its best estimate of losses as they occur. The accrued workers' compensation self-insurance liabilities of $10,670,607 and $9,996,921 at September 30, 2014 and 2013, respectively, have been discounted at 2.25%.

Effective October 1, 2006, the Hospital obtained "claims-made" medical malpractice insurance coverage, through the Network, from Healthcare Alliance Insurance Company, Ltd. (HAIC) under retrospectively-rated policies whose ultimate premium is based primarily on the Hospital's experience. HAIC is a multi-provider captive insurance company domiciled in the Cayman Islands. The Network is a one half owner of HAIC with one other local hospital that also holds a 50% ownership. The Hospital's insurance coverage is $1,500,000 per occurrence and $5,000,000 in the aggregate. In addition to the coverage from HAIC, the Hospital recorded reserves of approximately $1,747,604 and $2,066,103 at September 30, 2014 and 2013, respectively, related to claims that were incurred subsequent to October 1, 2006, but not yet reported. These reserves were discounted at 2.25% at September 30, 2014 and 2013.

The Hospital also obtains excess insurance coverage for professional and general liability, through the Network, from HAIC. These policies have limits of $25,000,000 per claim and $25,000,000 aggregate, in excess of the underlying limits in the primary layer, for both professional and general liability.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

MEDICAL MALPRACTICE AND WORKERS' COMPENSATION INSURANCE (CONTINUED)

The Hospital also purchased a loss transfer insurance policy which provides $1,000,000 of coverage for each medical incident that was incurred between October 1, 2003 and October 1, 2006 and specifically reported to the insurance company on the effective date of the transfer policy (February 7, 2008) in addition to medical incidents incurred during the aforementioned period which are first reported after the effective date of the policy. This policy also provides $1,000,000 of coverage for general liability incurred but not reported claims that occurred after October 1, 2003 through October 1, 2006 and were first reported after the effective date of the policy. The policy has annual aggregate limits of $4,500,000 for medical incidents and $3,000,000 for general liability cases with a combined $25,000,000 total limit for all policy years. These aggregate limits are eroded by claims previously paid by the Hospital or other insurance.

RETIREMENT BENEFIT PLANS

The Hospital maintains a defined benefit pension plan for eligible individuals and participates in two multi-employer pension plans that cover certain union employees. Reference is made to Note 9.

OTHER NONCURRENT LIABILITIES

Other noncurrent liabilities include the long-term portion of liabilities for medical malpractice, workers' compensation, retirement benefits, the interest rate swap, and conditional asset retirement obligations.

RISKS AND UNCERTAINTIES

The Hospital invests in a variety of investment securities which are exposed to various risks, such as interest rate risk, financial market risk, currency risk and credit risk. Due to the level of risk associated with investment securities, coupled with economic events, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the Hospital's September 30, 2014 financial statements, in addition to the funded status of its defined benefit pension plan.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

BAD DEBTS

ASU 2011-07, *Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*, requires certain health care entities to present the provision for bad debts associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense with enhanced footnote disclosures on the policies for recognizing revenue and assessing bad debts, in addition to qualitative and quantitative information about changes in the allowance for doubtful accounts. Refer to Note 2 for the additional disclosures required by ASU 2011-07.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE

The following table summarizes net patient service revenues:

	2014	2013
Gross patient service revenues	$985,407,726	$936,820,801
Deductions (additions)		
Allowances	734,714,169	683,010,134
Regulatory	1,857,243	(902,445)
	736,571,412	682,107,689
Net patient service revenues	248,836,314	254,713,112
Provision for bad debts	4,436,817	11,366,671
Net patient service revenues less provision for bad debts	$244,399,497	$243,346,441

Patient accounts receivable and revenues are recorded when patient services are performed.

Amounts received from most payors are different from the established billing rates of the Hospital, and these differences are accounted for as allowances. Net revenues have been affected by State of Connecticut Disproportionate Share program in 2014 and 2013 which is reflected in the regulatory amounts in the table above.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. For the years ended September 30, 2014 and 2013, the Hospital recorded approximately $2,500,000 and $2,400,000, respectively, as a decrease to net patient service revenues as changes in estimates related to third-party payor settlements and adjustments to accruals recorded in prior years.

During 2014 and 2013, approximately 44% and 37%, respectively, of net patient service revenues were received under the Medicare program, 10% and 16%, respectively, under the state Medicaid program, and 46% and 47%, respectively, from contracts with other third-parties.

Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital. The State of Connecticut has implemented reductions in the State's Disproportionate Share Reimbursement Program for the period from July 1, 2012 through June 30, 2015.

The current Connecticut Medicaid inpatient hospital reimbursement model of interim per diem rates and case rate settlements will transition to an All Patient Refined Diagnosis Related Group System (APR-DRG) where hospital payments will be established prospectively. Connecticut Medicaid outpatient hospital reimbursement will move from the current system of reimbursement based on Revenue Center Codes to a prospective payment system based on the complexity of services performed. The specific transition plan has not been finalized by the State of Connecticut, but the new inpatient reimbursement methodology may be implemented as early as January 1, 2015; while the new outpatient reimbursement methodology will not be implemented until at least the second half of fiscal year 2016. The Hospital has not determined the estimated impact of these proposed changes on net patient service revenues in future years.

The significant concentrations of net accounts receivable for services to patients include 44% from Medicare, 15% from Medicaid, 28% from commercial insurance carriers and 13% from others at September 30, 2014 (44%, 13%, 24% and 19%, respectively, in 2013).

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. The Hospital believes that it is in compliance with all applicable laws and regulations. Cost reports for the Hospital, which serve as a basis for final settlement with government payors, have been settled by final settlement through 2011 for Medicare and 1995 for Medicaid. Other years remain open for settlement.

The Hospital has agreements with various Health Maintenance Organi□ations (HMOs) to provide medical services to subscribing participants. Under these agreements, the HMOs make fee-for-service payments to the Hospital for certain covered services based upon discounted fee schedules.

ALLOWANCE FOR DOUBTFUL ACCOUNTS

The Hospital□s estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Hospital□s collection efforts. The Hospital□s policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as the charges are recorded. On a monthly basis, the Hospital reviews its accounts receivable balances, the effectiveness of the Hospital□s reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

- Revenue and volume trends by payor, particularly the self-pay components;
- Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;
- Various allowance coverage statistics.

The Hospital regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for doubtful accounts.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

ALLOWANCE FOR DOUBTFUL ACCOUNTS (CONTINUED)

A summary of the Hospital's allowance for doubtful accounts activity for the years ended September 30, 2014 and 2013 is as follows:

	Balance at Beginning of Period	Additions Recorded in the Provision for Bad Debts	Accounts Written off, Net of Recoveries and Other	Balance at End of Period
Allowance for doubtful accounts:				
Year ended September 30, 2013	$(11,683,000)	$(11,366,671)	$ 8,027,671	$(15,022,000)
Year ended September 30, 2014	(15,022,000)	(4,436,817)	10,251,817	(9,207,000)

MEASURING CHARITY CARE

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is possible. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized Federal poverty income levels, but also includes certain cases where incurred charges are significant when compared to incomes and assets. These services are not included in net patient service revenues for financial reporting purposes.

The Hospital implemented effective October 1, 2013 a change to its charity care policy to discount all self-pay receivables by 50 percent upon final billing. These self-pay discounts amounted to approximately $5.2 million for the year ended September 30, 2014 and were previously included in the provision for bad debts and the allowance for doubtful accounts.

Self-pay revenues are derived primarily from patients who do not have any form of health care coverage. The Hospital evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the Hospital's policy for charity care. The Hospital provides care without charge to certain patients that qualify under its charity care policy. For the years ended September 30, 2014 and 2013, the Hospital estimates that its costs of care provided under its charity care programs approximated $1,383,000 and $440,000, respectively.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

MEASURING CHARITY CARE (CONTINUED)

The Hospital's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Hospital's gross charity care charges provided. The Hospital's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Hospital's charity care policy. To the extent the Hospital receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Hospital does not include these patients' charges in its cost of care provided under its charity care program. Additionally, the Hospital does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Hospital's policy not to pursue collection of amounts related to these patients.

ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS

The American Recovery and Reinvestment Act of 2009 (ARRA) included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are also available to providers that adopt, implement or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

Income from Medicare incentive payments is recognized as revenue after the Hospital has demonstrated that it complied with the meaningful use criteria over the entire applicable compliance period. The Hospital recognized revenue from Medicaid and Medicare for incentive payments after it adopted certified EHR technology. Medicaid incentive payments were $322,653 and $483,979 for the years ended September 30, 2014 and 2013, respectively. Medicare incentive payments were $1,184,857 and $1,793,771 for the years ended September 30, 2014 and 2013, respectively. Incentive payments are included in other operating revenues in the accompanying consolidated statements of operations and changes in net assets. Income from incentive payments is subject to retrospective adjustment as the incentive payments are calculated using Medicare cost report data that is subject to audit. Additionally, the Hospital's compliance with the meaningful use criteria is subject to audit by the federal government.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

ICD-10 IMPLEMENTATION

The Hospital is subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically.

In January 2009, the Centers for Medicare and Medicaid Services (CMS) published its tenth revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the patient services provided in the Hospital will require much greater specificity when ICD-10 becomes effective on October 1, 2015.

The implementation of ICD-10 will require a significant investment in technology and training. The Hospital may experience delays in reimbursement while the Hospital and the payors from which it seeks reimbursement make the transition to ICD-10. If the Hospital fails to implement the new coding systems by the deadline, the Hospital will not be paid for services. Management is not able to reasonably estimate the overall financial statement impact of the Hospital's transition to ICD-10.

NOTE 3 - INVESTMENTS

The composition of investments, including other assets and funds held in escrow is set forth in the following table. Investments are stated at fair value:

	2014		2013	
	Cost	Fair Value	Cost	Fair Value
Short-term investments:				
Certificates of deposit and mutual funds	$ 424,925	$ 507,699	$ 406,088	$ 472,637
Investments of funds held in trust by others	$ 42,013,991	$ 46,117,761	$ 36,611,831	$ 44,960,039
Long-term investments and Board - designated endowment funds:				
Certificates of deposit and money market funds	$ 873,669	$ 873,669	$ 901,472	$ 901,472
Marketable equity securities	197,835	351,238	197,835	287,008
U.S. Government obligations	108,451	149,445	108,451	154,567
Corporate bonds	3,680,469	3,686,721	3,412,334	3,396,880
Mutual funds	7,799,302	9,013,644	7,708,657	8,908,523
	$ 12,659,726	$ 14,074,717	$ 12,328,749	$ 13,648,450

The Hospital had long-term investments in partnerships and joint ventures that were recorded at cost of $358,800 and $359,909 as of September 30, 2014 and 2013, respectively, as it was not practicable to estimate fair value. These investments are not included in the tables above.

Unrestricted investment income, including income on funds held in trust by others and gains are comprised of the following for the years ended September 30, 2014 and 2013:

	2014	2013
Income		
Interest and dividends	$ 1,832,085	$ 1,737,423
Realized gains on sales of investments	8,603	--
Changes in net unrealized gains on investments	92,827	268,235
	$ 1,933,515	$ 2,005,658

NOTE 4 - FAIR VALUE MEASUREMENTS

The Hospital categori□es assets and liabilities for disclosure purposes based on whether the inputs used to determine their fair values are observable or unobservable. The Hospital utili□es a three-level fair value hierarchy that prioriti□es the inputs used to measure assets at fair value. Level inputs are as follows:

Level 1 □ Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Hospital has the ability to access on the reporting date.

Level 2 □ Inputs other than □uoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset.

Level 3 □ Inputs that are unobservable for the asset or liability.

The fair values of Level 1 securities were determined through □uoted market prices, while fair values of Level 2 securities were determined primarily through prices obtained from third party pricing sources, where □uoted market prices for such securities are not available. The fair values of Level 3 securities were determined primarily through information obtained from the relevant counterparties for such assets or liabilities, as information on which these fair values are based is generally not readily available in the market.

The fair value of the interest rate swap was determined by the counterparty based on an estimate of the net present value of the expected cash flows using relevant mid-market data inputs and based on the assumption of no unusual market conditions or forced li□uidation.

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

The following table summarizes fair value measurements, by level, at September 30, 2014, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 35,728,709	$ --	$ --	$ 35,728,709
Common stock-Insurance	133,496	--	--	133,496
Mutual funds:				
U.S. large cap	21,147,966	--	--	21,147,966
U.S. mid cap	3,399,506	--	--	3,399,506
U.S. small cap	2,786,261	--	--	2,786,261
International developed	4,979,700	--	--	4,979,700
Emerging markets	3,076,127	--	--	3,076,127
Fixed income securities:				
Investment grade taxable	1,978,762	12,122,021	--	14,100,783
International developed bonds	--	695,404	--	695,404
Global high yield taxable	5,296	2,420,636	--	2,425,932
Real estate investment trusts	2,506,598	--	--	2,506,598
Other	1,758,038	546,588	--	2,304,626
Total investments at fair value	$ 77,500,459	$ 15,784,649	$ --	$ 93,285,108
Liabilities:				
Interest rate swap	$ --	$ 1,512,596	$ --	$ 1,512,596

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

The following table summarizes fair value measurements, by level, at September 30, 2013, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 31,081,328	$ --	$ --	$ 31,081,328
Common stock-Insurance	93,309	--	--	93,309
Mutual funds:				
U.S. large cap	23,645,248	--	--	23,645,248
U.S. mid cap	3,460,785	--	--	3,460,785
U.S. small cap	3,034,881	--	--	3,034,881
International developed	4,960,376	--	--	4,960,376
Emerging markets	2,705,380	--	--	2,705,380
Fixed income securities:				
Investment grade taxable	2,042,330	11,202,070	--	13,244,400
International developed bonds	1,237	719,184	--	720,421
Global high yield taxable	261,841	2,027,557	--	2,289,398
Real estate investment trusts	1,972,747	--	--	1,972,747
Other	101,506	284,678	--	386,184
Total investments at fair value	$ 73,360,968	$ 14,233,489	$ --	$ 87,594,457
Liabilities:				
Interest rate swap	$ --	$ 1,729,706	$ --	$ 1,729,706

NOTE 5 - RESTRICTED ENDOWMENTS

The Hospital's endowments consist of donor-restricted endowment funds and Board-designated endowment funds. Net assets associated with endowment funds are classified and reported based on donor-imposed restrictions.

The Hospital's Board of Trustees has interpreted the Connecticut Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and, if applicable (c) accumulations to the permanent endowment made in accordance with the related gift's donor instructions. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard for expenditure as proscribed by UPMIFA. In accordance with UPMIFA, the Hospital considers the following factors in making determinations to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund
(2) The purposes of the Hospital and the donor-restricted endowment fund
(3) General economic conditions
(4) The possible effect of inflation and deflation
(5) The expected total return from income and the appreciation of investments
(6) Other resources of the Hospital
(7) The investment policies of the Hospital

RETURN OBJECTIVES AND RISK PARAMETERS

For the permanently restricted endowment funds, the bank, acting in its capacity as trustee, determines and directs the investment policy and asset allocation. For the unrestricted and temporarily restricted endowment funds, the Hospital's Board of Trustees has adopted investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. The Hospital expects these endowment funds, over time, to provide an average rate of return that exceeds the rate of inflation by 3.5% annually. Actual returns in any given year may vary from this amount.

NOTE 5 - RESTRICTED ENDOWMENTS (CONTINUED)

STRATEGIES EMPLOYED FOR ACHIEVING OBJECTIVES

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

SPENDING POLICY AND HOW THE INVESTMENT OBJECTIVES RELATE TO SPENDING POLICY

The Hospital has a policy of evaluating the spending decisions for each endowment fund based upon the intentions of the donors and specific contractual agreements. In determining the annual amount to be spent, the Hospital considers the long-term expected return on its endowment. The spending policy is designed to limit spending to the expected long-term real rate of return. The annual distribution from the endowment funds is expected to be contained within a range of 4-6% of the trusts' market value. This is consistent with the Hospital's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2014

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 7,607,185	$ 48,909,797	$ 56,516,982
Board-designated endowment funds	3,315,500	--	--	3,315,500
Total funds	$ 3,315,500	$ 7,607,185	$ 48,909,797	$ 59,832,482

NOTE 5 - RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2014

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 3,193,664	$ 7,446,152	$ 47,752,075	$ 58,391,891
Investment return:				
Investment income	56,642	184,580	--	241,222
Net appreciation (realized and unrealized)	203,276	612,338	1,157,722	1,973,336
Total investment return	259,918	796,918	1,157,722	2,214,558
Appropriation of endowment assets for expenditure	(138,082)	(635,885)	--	(773,967)
Endowment net assets, ending balance	$ 3,315,500	$ 7,607,185	$ 48,909,797	$ 59,832,482

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 7,446,152	$ 47,752,075	$ 55,198,227
Board-designated endowment funds	3,193,664	--	--	3,193,664
Total funds	$ 3,193,664	$ 7,446,152	$ 47,752,075	$ 58,391,891

NOTE 5 - RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 2,974,503	$ 6,806,683	$ 45,010,199	$ 54,791,385
Investment return:				
Investment income	72,896	238,568	--	311,464
Net appreciation (realized and unrealized)	277,353	829,688	2,741,876	3,848,917
Total investment return	350,249	1,068,256	2,741,876	4,160,381
Appropriation of endowment assets for expenditure	(131,088)	(428,787)	--	(559,875)
Endowment net assets, ending balance	$ 3,193,664	$ 7,446,152	$ 47,752,075	$ 58,391,891

NOTE 6 - TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Permanently restricted net assets at September 30, 2014 and 2013 are restricted amounts which are to be held in perpetuity, the income from which is expendable to provide free care, scholarships for the children of the Hospital's employees, and for the operations of the Hospital. Also included in permanently restricted net assets are funds held in trust by others. The Hospital is the restricted income beneficiary of funds held in trust by others. The total trust assets, as reported by the trustees, had an aggregate fair value at September 30, 2014 and 2013 of $46,117,761 and $44,960,039, respectively. Distributions of $2,023,580 and $1,896,981 from these assets for the years ended September 30, 2014 and 2013, respectively, is included in investment income.

Temporarily restricted net assets are available to provide psychiatric services, free care and educational seminars.

NOTE 6 - TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS (CONTINUED)

During 2014 and 2013, net assets were released from donor restrictions by incurring expenses which satisfied the restricted purposes in providing grant related services, free care, and various miscellaneous services in the amounts of $4,369,303, $688,243 and $484,945, respectively in 2014 and $4,420,717, $657,253 and $341,621, respectively in 2013. In addition, $13,360 and $19,654 were released for the purchase of property and equipment in 2014 and 2013, respectively.

NOTE 7 - DEBT

SERIES D BOND FINANCING

In December 2010, the Hospital refinanced its Series C bond financing and financed an additional $8,000,000 for various capital projects that were completed over a two-year period. The par amount of the Series D debt was $25,918,000 and interest is variable at the interest rate that is equal to the product of (i) sixty-eight percent (68%) and (ii) the sum of the LIBOR Rate and three hundred basis points (2.15% at September 30, 2014). The bonds require monthly principal and interest payments, based upon a 10-year amortization schedule, from 2011 through 2020 with the remaining principal balance due in 2020.

The terms of the bonds provide for, among other things, a pledge of gross receipts of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and provide for covenants regarding the Hospital's debt service coverage ratios, minimum levels of cash on hand, sale and lease of assets and other covenants similar in financings of this type.

In connection with this refinancing, the Hospital entered into an interest rate swap with a bank, which allowed it to convert its variable interest rate liability to a fixed interest rate liability of 4.475% without changing the structure of the underlying debt.

The Hospital uses the interest rate swap agreement to manage interest rate risk associated with its outstanding debt. At September 30, 2014 and 2013, the notional value of outstanding interest rate swap was $24,283,520 and $24,755,656, respectively.

The Hospital recognizes the fair value of its interest rate swap in the consolidated balance sheet as a liability, recorded in other noncurrent liabilities. At September 30, 2014 and 2013, the fair value of interest rate swap was in a liability position of $1,512,596 and $1,729,706, respectively.

The Hospital designated its interest rate swap as a cash flow hedge for accounting purposes, and accordingly defers gains or losses associated with the swap in net assets.

NOTE 7 - DEBT (CONTINUED)

Future minimum payments by year and in the aggregate under the Series D bond financing are as follows at September 30, 2014:

2015	$ 493,776
2016	516,408
2017	540,080
2018	564,832
2019	590,716
Aggregate thereafter	21,577,708
	$ 24,283,520

OTHER DEBT

Access has a $250,000 line of credit with a bank. There were no borrowings under this line of credit at September 30, 2014 and 2013.

AMG had a capital lease for equipment that called for monthly payments of $593 through January 2014 and was secured by the equipment. The balance of the capital lease liability was $zero at September 30, 2014 and $2,858 at September 30, 2013.

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $353 through March 2015 and is secured by the equipment. The balance of the capital lease liability was $1,993 at September 30, 2014 and $5,877 at September 30, 2013.

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $447 through May 2015 and is secured by the equipment. The balance of the capital lease liability was $3,883 at September 30, 2014 and $8,687 at September 30, 2013.

AMG entered into a capital lease for equipment during 2014. The balance of the capital lease liability was $48,121 at September 30, 2014.

The Hospital entered into a capital lease for equipment during 2011. The lease calls for equal monthly payments of $20,885 through May 2016 and is secured by the equipment. The balance of the capital lease liability was $379,070 at September 30, 2014 and $609,435 at September 30, 2013.

NOTE 7 - DEBT (CONTINUED)

AMG entered into a term note during 2010 at an interest rate of 9.8%. The note calls for monthly payments of $13,216 through November 2014 and is secured by the assets of AMG. The balance of the term note liability was $26,101 at September 30, 2014 and $173,794 at September 30, 2013.

AMG assumed a note payable during 2009 for the fit-up of office space. The original amount of the note was $320,000 and was repayable in installments of principal plus interest at 7.50% totaling $4,908 per month through January 2014. In addition, this note called for a final payment of principal and interest of $113,981 in February 2014. The balance of this note was zero at September 30, 2014 and $129,815 at September 30, 2013.

The Hospital entered into a capital lease for equipment during 2012. The lease calls for equal monthly payments of $11,469 through August 2017 and is secured by the equipment. The balance of the capital lease liability was $376,940 at September 30, 2014 and $495,826 at September 30, 2013.

The Hospital entered into a capital lease for equipment during 2013. The lease calls for equal monthly payments of $4,779 through November 2015. The balance of capital lease liability was $64,581 at September 30, 2014 and $120,825 at September 30, 2013.

Future minimum payments by year and in the aggregate for all obligations other than the CHEFA Series D bonds were as follows at September 30, 2014:

2015	$ 461,705
2016	294,554
2017	138,132
2018	6,298
	$ 900,689

The fair value of the debt, using the discounted cash flow analyses, was approximately $26,697,000 at September 30, 2014 and $28,032,000 at September 30, 2013.

NOTE 8 - RENTAL EXPENSE AND LEASE COMMITMENTS

The Hospital has entered into operating leases for office space and office equipment. Rental expense is recorded on a straight-line basis over the terms of the leases. Rental expense for the years ended September 30, 2014 and 2013 was $4,441,474 and $4,740,477, respectively. The minimum rental commitments under all noncancellable operating leases with initial or remaining terms of more than one year are as follows:

2015	$ 4,241,725
2016	3,914,897
2017	2,892,657
2018	1,547,444
2019	114,032
Thereafter	195,408
	$ 12,906,163

NOTE 9 - EMPLOYEE BENEFIT PLANS

The Hospital has a noncontributory defined benefit cash balance plan (the Plan). Under the Plan, each participant who elected to transfer their balances to the Plan from the former defined contribution plan receives a credit of 6% of compensation allocated to their cash balance accounts. All other participants receive a 3% credit. Additionally, each participant receives an interest credit to their cash balance account based on the yield to maturity on three-year treasury bills. The Plan covers substantially all non-union employees age 21 and older with one year of service. It is the Hospital's policy to make contributions to the Plan sufficient to meet the minimum funding requirements of applicable laws and regulations.

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

Following is a summary of the Plan's funded status using the measurement dates of September 30, 2014 and 2013 and amounts recognized in the Hospital's consolidated financial statements.

	2014	2013
Change in benefit obligation		
Benefit obligation beginning of year	$ (35,562,211)	$ (37,888,825)
Service cost	(1,466,890)	(1,702,273)
Interest cost	(1,324,043)	(1,154,537)
Actuarial (loss) gain	(1,095,038)	2,126,771
Benefits paid	3,211,209	3,056,653
Benefit obligation, end of year	$ (36,236,973)	$ (35,562,211)
Change in plan assets		
Fair value of plan assets, beginning of year	$ 27,201,671	$ 28,843,113
Actual return on plan assets	696,625	253,055
Employer contributions	1,301,618	1,162,156
Benefits paid	(3,211,209)	(3,056,653)
Fair value of plan assets, end of year	$ 25,988,705	$ 27,201,671
Funded status	$ (10,248,268)	$ (8,360,540)
Accrued pension liability	$ (10,248,268)	$ (8,360,540)
Components of net periodic pension cost		
Service cost	$ 1,466,890	$ 1,702,273
Interest cost	1,324,043	1,154,537
Expected return on plan assets	(1,294,305)	(2,483,658)
Amortization of actuarial loss	816,016	971,872
Amortization of prior service cost	35,097	35,455
Net periodic pension cost	$ 2,347,741	$ 1,380,479
Accumulated benefit obligation	$ 35,271,477	$ 34,675,898

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

Included in unrestricted net assets are the following amounts that have not yet been recognized in net periodic cost:

	2014	2013
Unrecognized prior service cost	$ (121,434)	$ (156,531)
Unrecognized actuarial losses	(15,649,501)	(14,772,799)
Benefit obligation, end of year	$ (15,770,935)	$ (14,929,330)

Changes in benefit obligations recognized in unrestricted net assets include:

	2014	2013
Current year actuarial losses	$ (1,692,718)	$ (103,832)
Amortization of prior service cost	35,097	35,455
Amortization of net loss	816,016	971,872
	$ (841,605)	$ 903,495

The prior service cost and actuarial losses included in unrestricted net assets and expected to be recognized in net periodic cost during the year ending September 30, 2015 are $35,097 and $1,108,503, respectively.

ASSUMPTIONS

The weighted-average assumptions used to determine benefit obligations at September 30 are as follows:

	2014	2013
Discount rate	3.55%	3.99%
Expected return on plan assets	4.50%	8.00%
Rate of compensation increase	2.00% for 2 year select period, 3.00% ultimate	2.00% for 3 year select period, 3.00% ultimate

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

The weighted-average assumptions used to determine net periodic benefit cost for years ended September 30 are as follows:

	2014	2013
Discount rate	3.99%	3.17%
Expected return on plan assets	4.50%	8.00%
Rate of compensation increase	2.00% for 3 year select period, 3.00% ultimate	2.00% for 4 year select period, 3.00% ultimate

EXPECTED LONG-TERM RETURN ON PLAN ASSETS

To develop the expected long-term rate of return on assets assumptions, the Hospital considered the historical returns and the future expectations of returns for each asset class, as well as target asset allocations of the pension portfolio. This resulted in the selection of the 4.5% and 8.0% long-term rate of return at September 30, 2014 and 2013, respectively.

INVESTMENT POLICY

The Plan's weighted-average asset allocations at September 30, 2014, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
U.S. Equity	5%	5%	3% - 7%
Non-U.S. Equity	5%	5%	3% - 7%
Core fixed income	90%	90%	86% - 94%

The Plan's weighted-average asset allocations at September 30, 2013, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
Global defensive equity unhedged	10%	10%	5% - 15%
Custom fixed income	90%	90%	85% - 95%

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

The Pension Committee of the Board of Trustees (the Committee) is responsible for employee benefit program policies with respect to plan assets and the retention of qualified managers, consultants and trustee custodians. The purpose of the Committee is to ensure the Plan assets accumulate monies required to meet the anticipated benefit payments of the Plan and contributions are made by the Hospital on a basis determined by the Plan's actuary to be adequate to fund the benefits. The investment objective of the Committee is to maximize total return after inflation within the limits of prudent risk taking by diversifying across asset classes and multiple managers. The Committee has established an asset allocation policy that sets a target and range for each asset class, as shown in the table above.

CONTRIBUTIONS

The Hospital expects to make $1,204,000 in contributions to the Plan in 2015.

ESTIMATED FUTURE BENEFIT PAYMENTS

The following benefit payments, which reflect expected future service, are expected to be paid as follows:

2015	$ 3,388,000
2016	3,431,000
2017	3,305,000
2018	3,619,000
2019	3,287,000
2020-2024	15,109,000
	$ 32,139,000

As required by ASC 820, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

The following table sets forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2014.

	Level 1	Level 2	Level 3	Total
Commingled funds and private equity	--	--	$25,988,705	$25,988,705

The following table sets forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2013.

	Level 1	Level 2	Level 3	Total
Commingled funds and private equity	--	--	$27,201,671	$27,201,671

The following is a reconciliation of Level 3 assets for which significant unobservable inputs were used to determine fair value:

	2014	2013
Balance as of beginning of fiscal year	$ 27,201,671	$ 19,307,214
Change in unrealized appreciation (depreciation)	570,424	(487,433)
Purchases	5,571,007	52,316,941
Sales	(7,354,397)	(43,935,051)
Balance as of September 30,	$ 25,988,705	$ 27,201,671

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

OTHER BENEFIT PLANS

The Hospital participates in multi-employer pension plans that cover substantially all union employees. Contributions to the plans are based upon a percentage of each participant's total salary. The risks of participating in these multi-employer plans are different from single-employer plans in the following aspects:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of another participating employer.

- If a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers.

- If the Hospital chose to stop participating in the multi-employer plans, it would be required to pay those plans an amount based on the underfunded status of the plans, referred to as a withdrawal liability.

The following table presents the Hospital's participation in these plans as of and for the years ended September 30, 2014 and 2013.

Pension Trust Fund	Pension Plan Employer Identification Number	Pension Protection Act ("PPA") Certified Zone Status[1] 2014	2013	FIP/RP Status Pending/ Implemented[2]	Contributions 2014	2013	Surcharge Imposed	Expiration Date of Collection Bargaining Agreement[3]
Connecticut Health Care Associates Pension Fund	06-1313462	Green	Green	N/A	$2,074,142	$2,077,612	No	September 30, 2017
New England Health Care Employees Pension Fund	22-3071963	Green	Green	N/A	688,949	783,235	No	February 29, 2016
				Total Contributions:	$2,763,091	$2,860,847		

[1] The most recent PPA zone status available in 2014 and 2013 is for the plan's year-ending during 2013 and 2012, respectively. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.

[2] The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented.

[3] Lists the expiration dates of the collective-bargaining agreements to which the plans are subject.

During the years ended September 30, 2014 and 2013, the Hospital's contributions to the Connecticut Health Care Associates Pension Plan represented 98.6% and 96.0% of the total contributions made to the plan by all participating employers, respectively.

During the years ended September 30, 2014 and 2013, the Hospital's contributions to the New England Health Care Employees Pension Plan represented 2.8% and 3.0% of the total contributions made to the plan by all participating employers, respectively.

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. The Hospital has explored the costs to withdraw from the Connecticut Health Care Associates (CHCA) Pension Plan in the event that the Hospital enters into a transaction. If the Hospital was to withdraw, it is expected that CHCA will likewise withdraw from the pension plan making a total withdrawal liability for the Hospital of approximately $27,700,000.

In addition, the Hospital has a supplemental employee retirement plan for certain executives. The plan provides for a total benefit and is partially funded. As of September 30, 2014 and 2013, liabilities of $330,148 and $240,869, respectively, have been reflected in the consolidated balance sheets.

As noted above, the Hospital also has a noncontributory defined benefit cash balance plan covering substantially all non-union employees age 21 and older with one year of service. Total pension expense, relating to this plan, charged to operations during the years ended September 30, 2014 and 2013 was $2,347,741 and $1,380,479, respectively.

NOTE 10 - SELF-INSURANCE CLAIMS

There have been medical malpractice and workers compensation claims that fall within the Hospital's partially self-insured program which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2014 that may result in the assertion of claims. Hospital management has accrued its best estimate of these contingent losses. Other claims may be asserted arising from services provided to patients or workers compensation incidents in the past. Hospital management has provided reserves for these contingent liabilities.

NOTE 11 - CONTINGENCIES

The Hospital is a party to various lawsuits incidental to its business.

NOTE 12 - DUE TO AFFILIATES

The amounts due to affiliates of $600,116 and $2,042,951 at September 30, 2014 and 2013, respectively, represent (payables) to and receivables from affiliates that do not eliminate in consolidation. These balances are comprised of the following:

	2014	2013
Greater Waterbury Health Network, Inc.	$ (430,440)	$ (1,885,946)
Alliance Medical Group of Greater Waterbury, P.C.	(9,983)	(9,983)
Greater Waterbury Management Resources, Inc.	(162,693)	(162,693)
GI Co-Management Company	3,000	1,500
Children's Center of Greater Waterbury Health Network, Inc.	--	14,171
	$ (600,116)	$ (2,042,951)

NOTE 13 - FUNCTIONAL EXPENSES

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows:

	2014	2013
Health care services	$194,695,917	$193,831,378
General and administrative	67,341,789	63,524,487
Fundraising	377,435	352,305
	$262,415,141	$257,708,170

NOTE 14 - SUBSEQUENT EVENTS

The Hospital evaluates the impact of subsequent events, events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date or for disclosure in the notes to the financial statements. The Hospital evaluated events occurring subsequent to September 30, 2014 through December 19, 2014, the date on which the accompanying consolidated financial statements were available to be issued. During this period, there were no subsequent events that required recognition in the consolidated financial statements. Reference is made to Note 1 regarding the disclosure of subsequent events related to the proposed Joint Venture with Vanguard.

MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT ON OTHER FINANCIAL INFORMATION

Board of Trustees
The Waterbury Hospital

We have audited the consolidated financial statements of The Waterbury Hospital as of and for the years ended September 30, 2014 and 2013, and our report thereon dated December 19, 2014, which contained an unmodified opinion on those consolidated financial statements, appears on pages 1-2. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information is presented for the purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Marcum LLP

Hartford, CT
December 19, 2014

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2014

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Assets								
Current Assets								
Cash and cash equivalents	$ 26,817,453	$ 1,246,774	$ 2,192,258	$ 421,661	$ 1,048,604	$ 183,181	$ --	$ 31,909,931
Restricted cash	675,000	--	--	--	--	--	--	675,000
Short-term investments	--	--	507,699	--	--	--	--	507,699
Patient accounts receivable, net	26,853,209	874,082	1,610,880	--	1,428,376	479,375	(452,278)	30,793,644
Grants and other receivables	3,603,082	--	--	338	92,192	172,024	(23,874)	3,843,762
Inventories of supplies	3,694,606	--	30,346	--	185,876	3,117	--	3,913,945
Prepaid insurance and other expenses	1,493,653	--	54,850	4,814	235,813	134,222	--	1,923,352
Total Current Assets	63,137,003	2,120,856	4,396,033	426,813	2,990,861	971,919	(476,152)	73,567,333
Other Assets								
Funds held in trust by others	46,117,761	--	--	--	--	--	--	46,117,761
Long-term investments	11,017,660	38,776	61,581	--	--	--	--	11,118,017
Board-designated endowment funds	3,315,500	--	--	--	--	--	--	3,315,500
Other receivables	77,952	--	--	--	--	--	--	77,952
Goodwill	200,500	--	--	--	--	1,613,067	--	1,813,567
CHEFA obligations issue expense, less amortization	243,686	--	--	--	--	--	--	243,686
	60,973,059	38,776	61,581	--	--	1,613,067	--	62,686,483
Property, plant and equipment:								
Land	287,549	--	--	--	--	--	--	287,549
Buildings and improvements	89,842,088	1,150,645	557,686	1,670	2,634,456	121,621	--	94,308,166
Equipment	177,709,110	5,970,379	840,854	1,058,109	2,147,088	338,857	--	188,064,397
Less accumulated depreciation	(236,509,671)	(5,489,858)	(928,604)	(1,051,748)	(2,529,839)	(236,166)	--	(246,745,886)
	31,329,076	1,631,166	469,936	8,031	2,251,705	224,312	--	35,914,226
	$ 155,439,138	$ 3,790,798	$ 4,927,550	$ 434,844	$ 5,242,566	$ 2,809,298	$ (476,152)	$ 172,168,042

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2014

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Liabilities and Net Assets								
Current Liabilities								
Accounts payable and accrued expenses	$ 21,414,080	$ 523,448	$ 519,922	$ 12,854	$ 1,240,758	$ 87,858	$ (476,152)	$ 23,322,768
Salaries, wages, payroll taxes and amounts withheld from employees	7,138,794	--	215,139	--	1,051,000	1,436,967	--	9,841,900
Due to third-party reimbursement agencies	4,171,981	--	--	--	--	--	--	4,171,981
Current portion of CHEFA obligations	493,776	--	--	--	--	--	--	493,776
Current portion of notes payable and capital lease obligations	416,447	--	--	--	45,258	--	--	461,705
Due to (from) affiliates	2,916,986	--	--	(62,523)	(1,723,479)	(530,868)	--	600,116
Total Current Liabilities	36,552,064	523,448	735,061	(49,669)	613,537	993,957	(476,152)	38,892,246
Other Noncurrent Liabilities	25,163,807	--	--	--	191,170	--	--	25,354,977
CHEFA Obligations - less current portion	23,789,744	--	--	--	--	--	--	23,789,744
Notes Payable and Capital Lease Obligations - less current portion	404,144	--	--	--	34,840	--	--	438,984
Net Assets								
Unrestricted	11,890,055	2,091,104	2,725,118	411,836	4,403,019	1,815,341	--	23,336,473
Temporarily restricted	8,729,527	--	--	--	--	--	--	8,729,527
Permanently restricted	48,909,797	--	--	--	--	--	--	48,909,797
Total Net Assets Excluding Noncontrolling Interests	69,529,379	2,091,104	2,725,118	411,836	4,403,019	1,815,341	--	80,975,797
Noncontrolling Interests	--	1,176,246	1,467,371	72,677	--	--	--	2,716,294
Total Net Assets	69,529,379	3,267,350	4,192,489	484,513	4,403,019	1,815,341	--	83,692,091
	$ 155,439,138	$ 3,790,798	$ 4,927,550	$ 434,844	$ 5,242,566	$ 2,809,298	$ (476,152)	$ 172,168,042

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2013

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Assets								
Current Assets								
Cash and cash equivalents	$ 19,142,392	$ 1,262,636	$ 1,706,736	$ 359,845	$ 1,317,437	$ 204,377	$ --	$ 23,993,423
Restricted cash	4,519,908	--	--	--	--	--	--	4,519,908
Short-term investments	--	--	472,637	--	--	--	--	472,637
Patient accounts receivable, net	25,010,738	751,229	1,842,494	352	1,952,597	430,068	(546,352)	29,441,126
Grants and other receivables	3,065,683	--	--	--	503,555	185,477	(52,191)	3,702,524
Inventories of supplies	3,416,317	--	--	--	162,966	2,312	--	3,581,595
Prepaid insurance and other expenses	1,291,734	--	71,843	4,686	80,404	122,798	--	1,571,465
Total Current Assets	56,446,772	2,013,865	4,093,710	364,883	4,016,959	945,032	(598,543)	67,282,678
Other Assets								
Funds held in trust by others	44,960,039	--	--	--	--	--	--	44,960,039
Long-term investments	10,713,229	42,426	59,040	--	--	--	--	10,814,695
Board-designated endowment funds	3,193,664	--	--	--	--	--	--	3,193,664
Other receivables	171,972	--	--	--	--	--	--	171,972
Goodwill	200,500	--	--	--	--	1,613,067	--	1,813,567
CHEFA obligations issue expense, less amortization	282,676	--	--	--	--	--	--	282,676
	59,522,080	42,426	59,040	--	--	1,613,067	--	61,236,613
Property, plant and equipment:								
Land	287,549	--	--	--	--	--	--	287,549
Buildings and improvements	89,664,119	1,150,646	488,740	--	2,634,456	114,371	--	94,052,332
Equipment	176,657,750	5,970,380	766,531	1,134,076	2,040,925	342,599	--	186,912,261
Construction in progress	73,654	--	--	--	--	--	--	73,654
Less accumulated depreciation	(229,493,366)	(5,279,792)	(822,193)	(1,113,060)	(1,999,154)	(182,454)	--	(238,890,019)
	37,189,706	1,841,234	433,078	21,016	2,676,227	274,516	--	42,435,777
	$ 153,158,558	$ 3,897,525	$ 4,585,828	$ 385,899	$ 6,693,186	$ 2,832,615	$ (598,543)	$ 170,955,068

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2013

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Liabilities and Net Assets								
Current Liabilities								
Accounts payable and accrued expenses	$ 20,802,742	$ 348,614	$ 479,401	$ 19,215	$ 502,553	$ 24,245	$ (598,543)	$ 21,578,227
Salaries, wages, payroll taxes and amounts withheld from employees	5,298,046	--	159,713	--	505,210	1,432,042	--	7,395,011
Due to third-party reimbursement agencies	2,969,391	--	--	--	--	--	--	2,969,391
Current portion of CHEFA obligations	472,136	--	--	--	--	--	--	472,136
Current portion of notes payable and capital lease obligations	405,496	--	--	--	289,053	--	--	694,549
Due to (from) affiliates	1,795,348	--	--	(3,634)	690,250	(439,013)	--	2,042,951
Total Current Liabilities	31,743,159	348,614	639,114	15,581	1,987,066	1,017,274	(598,543)	35,152,265
Other Noncurrent Liabilities	21,482,020	--	--	--	331,487	--	--	21,813,507
CHEFA Obligations - less current portion	24,283,520	--	--	--	--	--	--	24,283,520
Notes Payable and Capital Lease Obligations - less current portion	820,591	--	--	--	31,977	--	--	852,568
Net Assets								
Unrestricted	18,667,399	2,271,303	2,565,364	314,770	4,342,656	1,815,341	--	29,976,833
Temporarily restricted	8,409,794	--	--	--	--	--	--	8,409,794
Permanently restricted	47,752,075	--	--	--	--	--	--	47,752,075
Total Net Assets Excluding Noncontrolling Interests	74,829,268	2,271,303	2,565,364	314,770	4,342,656	1,815,341	--	86,138,702
Noncontrolling Interests	--	1,277,608	1,381,350	55,548	--	--	--	2,714,506
Total Net Assets	74,829,268	3,548,911	3,946,714	370,318	4,342,656	1,815,341	--	88,853,208
	$ 153,158,558	$ 3,897,525	$ 4,585,828	$ 385,899	$ 6,693,186	$ 2,832,615	$ (598,543)	$ 170,955,068

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2014

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Unrestricted Revenues								
Net patient service revenues	$ 212,319,638	$ 4,424,791	$ 11,147,032	$ --	$ 16,873,540	$ 6,530,662	$ (2,459,349)	$ 248,836,314
Provision for (bad debts) recoveries	(3,692,986)	14,875	(108,185)	1,691	(518,641)	(133,571)	--	(4,436,817)
Net patient service revenues less provision for bad debts	208,626,652	4,439,666	11,038,847	1,691	16,354,899	6,397,091	(2,459,349)	244,399,497
Other operating revenues	2,671,751	--	1,039	163,293	4,595,487	1,762,014	(4,996,755)	4,196,829
Net assets released from restrictions	5,542,491	--	--	--	--	--	--	5,542,491
	216,840,894	4,439,666	11,039,886	164,984	20,950,386	8,159,105	(7,456,104)	254,138,817
Operating Expenses								
Salaries	83,908,937	727,282	6,832,163	--	17,793,489	8,789,526	--	118,051,397
Employee benefits	23,614,397	60,000	1,345,857	--	3,210,651	1,148,898	--	29,379,803
Supplies and other	100,656,298	1,916,231	1,756,019	44,660	7,534,825	1,286,065	(7,456,104)	105,737,994
Depreciation	6,921,086	213,716	110,717	6,034	531,675	77,732	--	7,860,960
Interest and amortization	1,352,572	--	--	--	32,415	--	--	1,384,987
	216,453,290	2,917,229	10,044,756	50,694	29,103,055	11,302,221	(7,456,104)	262,415,141
Income (Loss) from Operations	387,604	1,522,437	995,130	114,290	(8,152,669)	(3,143,116)	--	(8,276,324)
Nonoperating Gains								
Unrestricted gifts and bequests	1,240,261	--	--	--	--	--	--	1,240,261
Investment income	1,819,310	--	21,378	--	--	--	--	1,840,688
	3,059,571	--	21,378	--	--	--	--	3,080,949
Excess (Deficiency) of Revenues Over Expenses Before Changes in Net Unrealized Gains on Investments	3,447,175	1,522,437	1,016,508	114,290	(8,152,669)	(3,143,116)	--	(5,195,375)
Changes in Net Unrealized Gains on Investments	76,602	--	16,225	--	--	--	--	92,827
Excess (Deficiency) of Revenues Over Expenses	3,523,777	1,522,437	1,032,733	114,290	(8,152,669)	(3,143,116)	--	(5,102,548)
Less Excess of Revenue over Expenses Attributable to Noncontrolling Interests	--	--	--	--	--	--	(926,677)	(926,677)
Excess (Deficiency) of Revenues Over Expenses Attributable to Controlling Interest	$ 3,523,777	$ 1,522,437	$ 1,032,733	$ 114,290	$ (8,152,669)	$ (3,143,116)	$ (926,677)	$ (6,029,225)

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2013

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Unrestricted Revenues								
Net patient service revenues	$ 218,481,776	$ 4,496,888	$ 10,608,492	$ 172,403	$ 16,720,615	$ 6,426,998	$ (2,194,060)	$ 254,713,112
Provision for bad debts	(10,783,760)	29,929	(21,275)	--	(384,485)	(207,080)	--	(11,366,671)
Net patient service revenues less provision for bad debts	207,698,016	4,526,817	10,587,217	172,403	16,336,130	6,219,918	(2,194,060)	243,346,441
Other operating revenues	3,615,057	--	1,182	6,347	4,425,680	1,644,871	(4,483,169)	5,209,968
Net assets released from restrictions	5,419,591	--	--	--	--	--	--	5,419,591
	216,732,664	4,526,817	10,588,399	178,750	20,761,810	7,864,789	(6,677,229)	253,976,000
Operating Expenses								
Salaries	84,495,149	694,748	6,034,037	--	16,932,997	8,519,069	--	116,676,000
Employee benefits	25,316,268	85,023	1,245,184	--	3,120,845	1,146,177	--	30,913,497
Supplies and other	94,673,089	1,926,379	2,353,046	97,435	6,696,550	1,178,486	(6,677,229)	100,247,756
Depreciation	7,674,744	298,106	103,183	11,235	658,908	75,386	--	8,821,562
Interest and amortization	1,011,579	--	--	--	37,776	--	--	1,049,355
	213,170,829	3,004,256	9,735,450	108,670	27,447,076	10,919,118	(6,677,229)	257,708,170
Income (Loss) from Operations	3,561,835	1,522,561	852,949	70,080	(6,685,266)	(3,054,329)	--	(3,732,170)
Nonoperating Gains								
Unrestricted gifts and bequests	217,275	--	--	--	--	--	--	217,275
Investment income	1,722,250	--	15,173	--	--	--	--	1,737,423
	1,939,525	--	15,173	--	--	--	--	1,954,698
Excess (Deficiency) of Revenues Over Expenses Before Changes in Net Unrealized Gains on Investments	5,501,360	1,522,561	868,122	70,080	(6,685,266)	(3,054,329)	--	(1,777,472)
Changes in Net Unrealized Gains on Investments	233,353	--	34,882	--	--	--	--	268,235
Excess (Deficiency) of Revenues Over Expenses	5,734,713	1,522,561	903,004	70,080	(6,685,266)	(3,054,329)	--	(1,509,237)
Less Excess of Revenue over Expenses Attributable to Noncontrolling Interests	--	--	--	--	--	--	(874,685)	(874,685)
Excess (Deficiency) of Revenues Over Expenses Attributable to Controlling Interest	$ 5,734,713	$ 1,522,561	$ 903,004	$ 70,080	$ (6,685,266)	$ (3,054,329)	$ (874,685)	$ (2,383,922)

See independent auditors' report on other financial information.

Form **990-T**

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

For calendar year 2013 or other tax year beginning OCT 1, 2013 , and ending SEP 30, 2014

▶ Information about Form 990-T and its instructions is available at *www.irs.gov/form990t.*

▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

OMB No 1545-0687

2013

Open to Public Inspection for 501(c)(3) Organizations Only

Department of the Treasury
Internal Revenue Service

A ☐ Check box if address changed

B Exempt under section
☒ 501(C)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
THE WATERBURY HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
64 ROBBINS STREET

City or town, state or province, country, and ZIP or foreign postal code
WATERBURY, CT 06708

D Employer identification number (Employees' trust, see instructions.)
06-0665979

E Unrelated business activity codes (See instructions.)
621500 811000

C Book value of all assets at end of year
172168042.

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ SEE STATEMENT 1

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 3

J The books are in care of ▶ SCOTT BOWMAN Telephone number ▶ 203-573-7333

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales 2,213,525. b Less returns and allowances 1,651,756. c Balance ▶	1c	561,769.		
2 Cost of goods sold (Schedule A, line 7)	2			
3 Gross profit. Subtract line 2 from line 1c	3	561,769.		561,769.
4a Capital gain net income (attach Form 8949 and Schedule D)	4a			
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c Capital loss deduction for trusts	4c			
5 Income (loss) from partnerships and S corporations (attach statement)	5			
6 Rent income (Schedule C)	6			
7 Unrelated debt-financed income (Schedule E)	7			
8 Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10 Exploited exempt activity income (Schedule I)	10			
11 Advertising income (Schedule J)	11			
12 Other income (See instructions; attach schedule.)	12			
13 **Total.** Combine lines 3 through 12	13	561,769.		561,769.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.)
(Except for contributions, deductions must be directly connected with the unrelated business income.)

14	Compensation of officers, directors, and trustees (Schedule K)		14	
15	Salaries and wages		15	104,373.
16	Repairs and maintenance		16	
17	Bad debts		17	
18	Interest (attach schedule)		18	
19	Taxes and licenses		19	
20	Charitable contributions (See instructions for limitation rules)		20	
21	Depreciation (attach Form 4562)	21 2,452.		
22	Less depreciation claimed on Schedule A and elsewhere on return	22a	22b	2,452.
23	Depletion		23	
24	Contributions to deferred compensation plans		24	
25	Employee benefit programs		25	29,374.
26	Excess exempt expenses (Schedule I)		26	
27	Excess readership costs (Schedule J)		27	
28	Other deductions (attach schedule) SEE STATEMENT 2		28	472,598.
29	**Total deductions.** Add lines 14 through 28		29	608,797.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13		30	-47,028.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 4		31	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30		32	-47,028.
33	Specific deduction (Generally $1,000, but see instructions for exceptions.)		33	1,000.
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32		34	-47,028.

Part III Tax Computation

35	**Organizations Taxable as Corporations.** See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here ▶ [X] **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ 50,000. (2) $ 25,000. (3) $ 9,925,000.		
b	Enter organization's share of: (1) Additional 5% tax (not more than $11,750) $		
	(2) Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from: [ ] Tax rate schedule or [ ] Schedule D (Form 1041) ▶	36	
37	**Proxy tax.** See instructions ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: [ ] Form 4255 [ ] Form 8611 [ ] Form 8697 [ ] Form 8866 [ ] Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2012 overpayment credited to 2013	44a			
b	2013 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: [ ] Form 2439 [ ] Form 4136 [ ] Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ [ ]			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2014 estimated tax** ▶ **Refunded** ▶			49	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

		Yes	No
1	At any time during the 2013 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
4a	Additional section 263A costs (attach schedule)	4a					
b	Other costs (attach schedule)	4b					
5	**Total.** Add lines 1 through 4b	5					

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge

▶ _____ Signature of officer Date ▶ PRESIDENT/TREASURER Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes [ ] No

Paid Preparer Use Only

Print/Type preparer's name: DOUGLAS FARRINGTON	Preparer's signature: [signature]	Date: 8/10/15	Check [ ] if self-employed; PTIN: P00370668
Firm's name ▶ MARCUM LLP			Firm's EIN ▶ 11-1986323
Firm's address ▶ CITY PLACE II 185 ASYLUM STREET HARTFORD, CT 06103			Phone no. 860-760-0600

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property (a) Straight line depreciation (attach schedule)	3. (b) Other deductions (attach schedule)
(1)			
(2)			
(3)			
(4)			

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A)	Enter here and on page 1, Part I, line 7, column (B)
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations 3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

Nonexempt Controlled Organizations

	7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)					
(2)					
(3)					
(4)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A)	Add columns 6 and 11 Enter here and on page 1, Part I, line 8, column (B)
Totals ▶				0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization
(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals ▶	Enter here and on page 1, Part I, line 9, column (A). 0.			Enter here and on page 1, Part I, line 9, column (B). 0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income
(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals ▶	Enter here and on page 1, Part I, line 10, col. (A). 0.	Enter here and on page 1, Part I, line 10, col. (B) 0.				Enter here and on page 1, Part II, line 26. 0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4)
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
Totals, Part II (lines 1-5) ▶	Enter here and on page 1, Part I, line 11, col. (A) 0.	Enter here and on page 1, Part I, line 11, col. (B) 0.				Enter here and on page 1, Part II, line 27. 0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

Form **8868**
(Rev. January 2014)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

▶ **File a separate application for each return.**

▶ **Information about Form 8868 and its instructions is at** *www.irs.gov/form8868* .

OMB No. 1545-1709

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** and check this box ▶ ☐
- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** (on page 2 of this form).

Do not complete Part II unless you have already been granted an automatic 3-month extension on a previously filed Form 8868.

Electronic filing *(e-file)* . You can electronically file Form 8868 if you need a 3-month automatic extension of time to file (6 months for a corporation required to file Form 990-T), or an additional (not automatic) 3-month extension of time. You can electronically file Form 8868 to request an extension of time to file any of the forms listed in Part I or Part II with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, which must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit *www.irs.gov/efile* and click on *e-file for Charities & Nonprofits*.

Part I Automatic 3-Month Extension of Time. Only submit original (no copies needed).

A corporation required to file Form 990-T and requesting an automatic 6-month extension - check this box and complete Part I only ▶ ☒

All other corporations (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	**Enter filer's identifying number** Employer identification number (EIN) or
	THE WATERBURY HOSPITAL	06-0665979
	Number, street, and room or suite no. If a P.O. box, see instructions. 64 ROBBINS STREET	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. WATERBURY, CT 06708	

Enter the Return code for the return that this application is for (file a separate application for each return) ▶ 0 7

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ▶ SCOTT BOWMAN 64 ROBBINS STREET - WATERBURY, CT 06708
  Telephone No. ▶ 203-573-7333 Fax No. ▶
- If the organization does not have an office or place of business in the United States, check this box ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐ . If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until AUGUST 15, 2015 , to file the exempt organization return for the organization named above. The extension is for the organization's return for:
▶ ☐ calendar year _____ or
▶ ☒ tax year beginning OCT 1, 2013 , and ending SEP 30, 2014 .

2 If the tax year entered in line 1 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

3a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a	$	0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	3b	$	0.
c	**Balance due.** Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c	$	0.

Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

FORM 990-T DESCRIPTION OF ORGANIZATION'S PRIMARY UNRELATED BUSINESS ACTIVITY STATEMENT 1

NONPATIENT LABORATORY SERVICES AND IMAGING REPAIR & MAINTENANCE

TO FORM 990-T, PAGE 1

FORM 990-T OTHER DEDUCTIONS STATEMENT 2

DESCRIPTION	AMOUNT
SUPPLIES	311,446.
INDIRECT COSTS	161,152.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	472,598.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 3

CORPORATION'S NAME	IDENTIFYING NO
GREATER WATERBURY HEALTH NETWORK, INC.	22-2572044

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/13	26,894.	0.	26,894.	26,894.
NOL CARRYOVER AVAILABLE THIS YEAR			26,894.	26,894.

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T
Connecticut Unrelated Business Income Tax Return

2013

Complete this return in blue or black ink only.

Enter Income Year Beginning ▶ OCTOBER 1 , 2013, and Ending ▶ SEPTEMBER 30, 2014

Taxpayer (Please type or print)

Organization name *(please type or print)*: THE WATERBURY HOSPITAL

Address — Number and street — PO Box: 64 ROBBINS STREET

City or town — State — ZIP code: WATERBURY, CT 06708

CT Tax Registration Number ▶

DRS use only ▶ - - 20

Federal Employer ID Number (FEIN): 06-0665979

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) **Return status:** ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized; Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: NONPATIENT LABORATORY SERVICES AND IMAGING
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut: _____

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2013 federal Form 990-T, Part II, Line 34 ▶	1	-47,028	00
2. Federal net operating loss deduction from 2013 federal Form 990-T, Part II, Line 31 ▶	2		00
3. Federal deduction for Connecticut tax on unrelated business taxable income ▶	3		00
4. **Total:** Add Lines 1, 2, and 3 ▶	4	-47,028	00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income ▶	5		00
6. Unrelated business taxable income: Subtract Line 5 from Line 4 ▶	6	-47,028	00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3** ▶	1	-47,028	00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places ▶	2		
3. Connecticut unrelated business taxable income: Line 1 **or** Line 1 multiplied by Line 2 ▶	3	-47,028	00
4. Operating loss carryover from *Schedule B*, Line 14 on page 2 ▶	4		00
5. Income subject to tax: Subtract Line 4 from Line 3 ▶	5	-47,028	00
6. **Tax:** Multiply Line 5 by 7.5% (.075) ▶	6		00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions ▶	1		00
2. *Reserved for future use* ▶	2		
3. Total Tax: Enter the amount from Line 1 ▶	3		00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1** ▶	4		00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0." ▶	5	0	00
6a. Paid with application for extension from **Form CT-990T EXT** ▶	6a		00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC, & ESD** ▶	6b		00
6c. Overpayment from prior year ▶	6c		00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c ▶	6		00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5 ▶	7	0	00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ CT-1120I Interest ▶ (8c) _____	8		00
9. Amount to be credited to 2014 estimated tax ▶ (9a) Refunded ▶ (9b)	9		00

For a faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8 ▶	10	0	00

Visit the DRS website at www.ct.gov/DRS **www.ct.gov/TSC** to pay electronically. TSC Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Name of officer or fiduciary *(print)*: DARLENE STROMSTAD	Signature of officer or fiduciary	Date
	Officer's email address *(print)*		May DRS contact the preparer shown below about this return? See instructions. ☒ Yes ☐ No
Keep a copy of this return for your records.	Title: PRESIDENT/TREASURER	Telephone number: (203)573-6000	
	Paid preparer's signature	Date: 8/10/15	Preparer's SSN or PTIN: P00370668
	Firm's name and address: MARCUM LLP CITY PLACE II 185 ASYLUM STREET HARTFORD, CT 06103	FEIN: 11-1986323	Telephone number: 860-760-0600

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Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut	Column B Everywhere	Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories	00	00	
	(b) Tangible property	00	00	
	(c) Real property	00	00	
	(d) Capitalized rent	00	00	
	1. Total	00	00	
Receipts	2. (a) Sales of tangibles	00	00	
	(b) Services	00	00	
	(c) Rentals	00	00	
	(d) Other	00	00	
	2. Total	00	00	
Wages, salaries, and other compensation	**3. Total**	00	00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.			
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.			

Schedule B - Connecticut Apportioned Operating Loss Carryover Applied to 2013

1. 2000 Connecticut net operating loss available for use in 2013	1.		00
2. 2001 Connecticut net operating loss available for use in 2013	2.		00
3. 2002 Connecticut net operating loss available for use in 2013	3.		00
4. 2003 Connecticut net operating loss available for use in 2013	4.		00
5. 2004 Connecticut net operating loss available for use in 2013	5.		00
6. 2005 Connecticut net operating loss available for use in 2013	6.		00
7. 2006 Connecticut net operating loss available for use in 2013	7.		00
8. 2007 Connecticut net operating loss available for use in 2013	8.		00
9. 2008 Connecticut net operating loss available for use in 2013	9.		00
10. 2009 Connecticut net operating loss available for use in 2013	10.		00
11. 2010 Connecticut net operating loss available for use in 2013	11.		00
12. 2011 Connecticut net operating loss available for use in 2013	12.		00
13. 2012 Connecticut net operating loss available for use in 2013	13.	25,894	00
14. **Total:** Add Lines 1 through 13. Enter here and on *Computation of Tax*, Line 4	14.	25,894	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.	-47,028	00
2. Add back specific deduction from 2013 federal Form 990-T, Part II, Line 33	2.	1,000	00
3. Subtotal: Add Line 1 and Line 2	3.	-46,028	00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2013 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.	-46,028	00

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T EXT

Application for Extension of Time to File Unrelated Business Income Tax Return

See instructions. Complete this return in blue or black ink only.

2013

Enter Income Year Beginning ▶ OCT 1 , 2013, and Ending ▶ SEP 30, 2014

Taxpayer (Please type or print)

Organization name *(please type or print)*: THE WATERBURY HOSPITAL

Address — Number and street — PO Box: 64 ROBBINS STREET

City or town — State — ZIP code: WATERBURY, CT 06708

CT Tax Registration Number ▶

DRS use only ▶ - - 20

Federal Employer ID Number (FEIN) ▶ 06-0665979

Request for six-month extension of time to file Form CT-990T only

Enter above the beginning and ending dates of the organization's income year, Connecticut Tax Registration Number, and FEIN.

Check type of organization: [X] Corporation [ ] Domestic trust [ ] Foreign trust [ ] Other

An application for an extension to file **Form CT-990T**, with payment of tax tentatively believed to be due, must be submitted whether or not an application for federal extension has been approved.

I request a **six-month extension** of time to file **Form CT-990T**, *Connecticut Unrelated Business Income Tax Return*, for calendar year 2013, or until 08/17/15 for fiscal year ending 09/30/14.

A federal extension will be requested on federal Form 8868, Application for Extension of Time to File an Exempt Organization Return, for calendar year 2013, or fiscal year beginning OCTOBER 1, 2013, and ending SEPTEMBER 30, 2014. [X] Yes [ ] No

If No, the reason for the Connecticut extension is _____

Notification will be sent only if extension request is denied

Tentative Return

Computation

1.	Tentative amount of tax due for this income year, including surtax if applicable. See instr.			1.	00
2.	*Reserved for future use*			2.	
3.	Total amount of tax due for this income year: Enter amount from Line 1			3.	00
4a.	Tax credits	4a	00		
4b.	Payments of estimated tax	4b	00		
4c.	Overpayment from prior year	4c	00		
4.	Total tax credits and payments: Add Lines 4a, 4b, and 4c			4.	00
5	**Balance due with this return:** Subtract Line 4 from Line 3 ▶			5.	0 00

Make check payable to **Commissioner of Revenue Services.** Write the organization's Connecticut Tax Registration Number and "2013 Form CT-990T EXT" on the check and attach it to the return.

Mail this return to: Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014

Visit the DRS **Taxpayer Service Center (TSC)** at **www.ct.gov/TSC** to pay this return electronically.

www.ct.gov/DRS TSC Taxpayer Service Center

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Name of officer or fiduciary *(print)*	Signature of officer or fiduciary	Date

Officer's email address *(print)*

Title	Telephone number	
Paid preparer's signature Patricia Tate	Date 2/10/15	Preparer's SSN or PTIN P01325330
Firm's name and address MARCUM LLP CITY PLACE II 185 ASYLUM STREET HARTFORD, CT 06103	FEIN 11-1986323	Telephone number 860-549-8500

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14410205 756977 WATERHSP 2013.05050 THE WATERBURY HOSPITAL WATERHS1

EXHIBIT Q58-1 - PMH HOSPITAL ACQUISITIONS

Nix Health System

Texas – San Antonio

- Nix Health System
  - Acute Care Hospital
  - Rural Acute Care Hospital
  - Psychiatric Hospital
  - Specialty Hospital

  - 19 Primary and Specialty Clinics
  - Medical Groups Under Development
  - Centers of Excellence:
    - Behavioral/ Psychiatric Center of Excellence
    - Orthopedic Surgery of Excellence
    - Bariatric Surgery Of Excellence

Record of Performance

Texas - Nix Health

- **Transaction completed on 2/1/12**
  - First Entry in Texas Market for Prospect Medical

- **Accomplishments Since Nix Acquisition**
  - Formed a Medical Group
  - Forming a Multi-Specialty IPA – Integration with Behavioral Health
  - Expanded Behavioral Health services with addition of a 45 bed facility
  - Expanded Hospital-Based Outpatient Clinics
  - Purchase of Rural Hospital expanding the System
  - Converted Urgent Care Center to an Emergency Room
  - Entered into Risk Contracting with Major Insurers
  - Measurable Improvements in Quality Metrics

Prospect CharterCare Hospitals - RI

Our Lady of Fatima Hospital, a 278-bed acute care facility, is RI's only Catholic sponsored hospital providing an array of medical and surgical services.

Roger Williams Medical Center is a 220-bed acute care hospital and academic teaching and research affiliate of Boston University School of Medicine.

Elmhurst Extended Care is RI's only long-term facility affiliated with a hospital system and offers short-term, long-term and specialized elder care.

St. Joseph Health Center is a network of primary care programs and specialty services for underserved children and families.

Prospect CharterCare – Record of Performance

Entrance into Market

- Acquired system June 2014 (Two hospitals / Specialty Health Center / Nursing Home)

Project Commitments 2015 ($20M)

- Cancer Center
- Digestive Diseases Center
- Emergency Department
- Physician Practice Purchases

Proposed Service Lines

- OB
- Cardiac Cath

Model Implementation

- Quickly cleared regulatory hurdles to implement risk taking model
- Developed an IPA and recruited 105 PCPs / 270 specialists
- Negotiated risk contract with largest payer in state
- Medicare Select narrow network product with largest payer
- Went from 0 to 6,500 Medicare Advantage lives under population health management
- Grew from 20 to 81 providers
- $24M financial turnaround

What's Next – Road Ahead

- Coordinated Care Pilot Program accepted by State. Projected to carve costs out of State budget and generate savings to RI of $18M/3 years.
- A working model for Coordinated Care in the North East that can be used for further development
- Recognition by State's healthcare and political leaders for ability to transform the Healthcare Delivery Model

Bellflower and Tustin Hospitals

- **Transaction completed in May 2014**
  - Tustin Hospital - 177 Bed Facility
  - Bellflower - 80 Bed Facility

Both Hospitals had been closed for 1 year by the previous owner.

- **Accomplishments:**
  - Tustin:
    - Re-opening of Acute Care and Emergency Services.
    - Opened an Urgent Care
  - Bellflower:
    - Initial services include a 32 bed Behavioral unit.
    - Working with the community and local officials on a strategic plan for additional services.

01409

From:	Lazarus, Steven
To:	Ann H. Zucker; michelemvolpe@aol.com
Cc:	Hawes, Gary W.; Martone, Kim; Greer, Leslie; Hansted, Kevin; Cotto, Carmen
Subject:	DNs: 15-32017-486 and 15-486-02 Waterbury Health Network and Prospect Medical Holdings-Completeness Letter
Date:	Tuesday, November 17, 2015 3:39:28 PM
Attachments:	15-32017-486 and 15-486-02.pdf 15-32017-486 and 15-486-02 GWHN - Prospect-Waterbury Completeness Letter.docx

Good Afternoon,

Please see the attached Completeness Letter for the above referenced proposal filed with the Office of the Attorney General and The office of Health Care Access (Department of Public Health). If you have any questions, please do not hesitate to contact Gary Hawes or myself.

Sincerely,

Steven

Ps. Attached files include the actual signed PDF copies, as well as the electronic copy in Word for your convenience.

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

DR. JEWEL MULLEN
COMMISSIONER

November 17, 2015

VIA U.S. and ELECTRONIC MAIL
Darlene Stromstad, FACHE
President/CEO
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06708

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02

Dear Ms. Stromstad and Mr. Spees:

On October 28, 2015, the Application of Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH") was filed with the Office of Health Care Access, Department of Public Health ("OHCA/DPH") and Office of the Attorney General ("OAG") for the transfer of substantially all of the assets of GWHN and its related affiliates to PMH or one or more of its affiliates.

The OAG and OHCA/DPH have determined that there are deficiencies in the Application that require clarification and/or additional production. Conn. Gen. Stat. § 19a-486a(d). Accordingly, please respond to the following questions and/or submit the following materials to the OAG and OHCA by January 18, 2016.

OHCA Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Service*	Actual Volume (Last 3 Completed FYs)			
	FY**	FY**	FY**	CFY***
Medical/Surgical Maternity Psychiatric Pediatric Rehabilitation				
Total				

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

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

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

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY**	FY**	FY**	CFY***
Medical/Surgical Maternity Psychiatric Pediatric Rehabilitation				
Total				

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

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

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

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

TABLE C
PROJECTED DISCHARGES BY SERVICE

Service*	Projected Volume			
	FY**	FY**	FY**	FY**

Medical/Surgical Maternity Psychiatric Pediatric Rehabilitation				
Total				

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

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

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

	Projected Volume			
Service*	FY**	FY**	FY**	FY**
Medical/Surgical Maternity Psychiatric Pediatric Rehabilitation				
Total				

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

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

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

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

15. At page 13 of the Application, Applicants describe the Hospital as a "safety net" hospital that treats "a large number of Medicare, Medicaid and uninsured patients." Additionally,

Applicants state on page 54, that Waterbury struggles with high unemployment and high poverty. Applicants state that the Asset Purchase will provide access to capital that will allow the Hospital to recruit additional physician and midlevel providers. With respect to these statements, address the following:

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

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

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

TABLE E

	2013	2014	2015
Active Staff			
Total Staff			

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

continue ECHN's charity policies. Please explain the parties' decision to agree to this qualification.

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

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

TABLE F

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

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

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

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

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

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

24. Subsequent to acquisition of both hospitals, describe PMH's experience in implementing the Community Health Needs Assessment ("CHNA") implementation strategies for both Roger

Williams Medical Center and Our Lady of Fatima Hospital. Please describe the priority needs identified in each CHNA and how each hospital is presently addressing those needs.

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

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

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

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

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

a) Waterbury Hospital Infectious Disease Clinic

b) Waterbury Health Access Program

c) Waterbury Hospital Center for Behavioral Health

d) Be Well Bus

e) Heart Center of Greater Waterbury

f) Family Birthing Center

g) Thank God I'm Female

h) Evergreen 50 Club

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

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

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

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

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

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

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

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

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

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

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

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

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

d) For GWHN and Waterbury Hospital, explain why the applicants assumed increases in expenses, for FY 2016-FY 2018, when in response to questions 26 and 53, the Applicants indicate that they expect a lower cost structure and improved efficiencies that will generate cost savings and that, as stated in Exhibit Q38-1, "*the hospital engaged the Camden Group to look at opportunities to remove expenses from the organization and we have begun or about to begin implementing many of these based on the data analyzed. Our goal moving forward and starting in FY 2016 is to increase our revenue capability but also make significant changes that will allow us to decrease our expenses where appropriate.*"

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

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

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

OAG Questions

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

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

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

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

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

After receipt of these requested materials, the OAG and OHCA shall review the submission to determine whether the application for approval is complete. If not, they shall provide written notice of any deficiencies within twenty (20) days of receipt of the information requested. Should you have any questions regarding these requests or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General
Office of the Attorney General

Very truly yours,

Kimberly Martone
Director of Operations
Office of Health Care Access

cc: Steven Lazarus (via electronic mail)
Counsel of Record

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: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: December 16, 2015

RE: Certificate of Need Application; Docket Number: 15-32017-486
Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc.
Greater Waterbury Health Network, Inc. Proposed Asset Purchase by
Prospect Medical Holdings, Inc..

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

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707 Summer Street
Stamford, CT 06901

December 24, 2015

VIA HAND DELIVERY

Office of the Attorney General
55 Elm St.
P.O. Box 120
Hartford, CT 06141-0120
Attn: Atty. Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capital Avenue
Hartford, CT 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02

Dear Mr. Hawes and Mr. Lazarus:

Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. hereby submit the enclosed responses to the completeness questions issued by the Office of the Attorney General and the Office of Health Care Access on November 17, 2015.

At your request, one (1) hard copy and (1) electronic copy have been provided to each Office. If you have any questions or need anything further, please feel free to contact Ann Zucker at (203) 252-2652 or Michele Volpe at (203) 777-6995. Thank you for your assistance in this matter.

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Very truly yours,

Carmody Torrance Sandak & Hennessey LLP

By: _____
Ann H. Zucker
Its Partner

Bershtein Volpe & McKeon, P.C.

By: _____
Michele Volpe
Its Partner

cc. Kimberly Martone, Director of Operations, Department of Public Health
Division of Office of Health Care Access
Jonathan Spees, Prospect Medical Holdings, Inc. (via regular mail)
Darlene Stromstad, Greater Waterbury Health Network, Inc. (via regular mail)

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

OHCA Questions

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

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

Response:

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

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

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

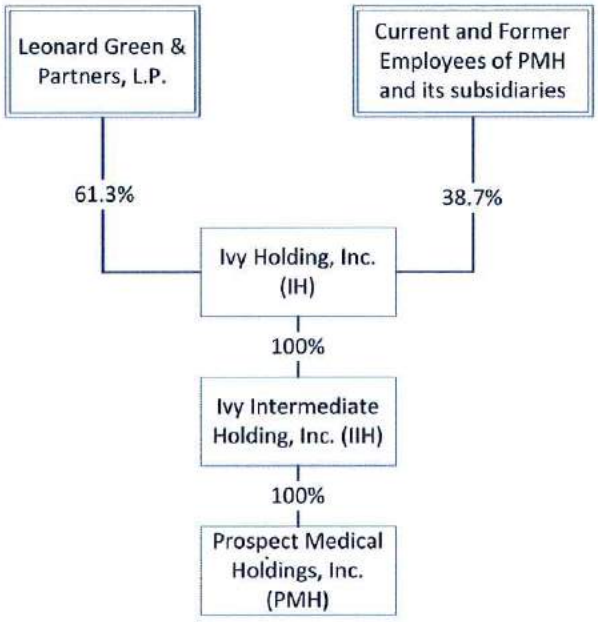
About Leonard Green & Partners, L.P. ("Leonard Green") - Source: www.leonardgreen.com

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

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

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

Figure 1 – Relationship of Leonard Green to PMH



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

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

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

Response:

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

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

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

Response:

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

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

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

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

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

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

Response:

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

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

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

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

Response:

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

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

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

Response:

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

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

Response:

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

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

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

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

Response:

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

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

Response:

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

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

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

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

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

Response:

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

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

Response:

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

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

Response:

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

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

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

Response:

GWHN FILING TABLES

	Balance Sheet as of 9/30/2015 (Ownership Adjusted)	Pro Forma: Retained by Surviving Entity	Pro Forma: Purchased/ Assumed by Prospect
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 22,050,744	$ 22,050,744	$ -
Short-term Investments	$ 1,496,670	$ 1,496,670	$ -
Net Accounts Receivable	$ 31,922,600	$ 176,254	$ 31,753,355
Accts Receivable - Other	$ 3,944,727	$ 3,412,833	$ 531,894
Inventories	$ 3,440,371	$ -	$ 3,449,371
Prepaid Insurance and Other Expenses	$ 2,035,847	$ 204,631	$ 1,831,216
Due From Affiliates	$ (248,126)	$ (248,126)	$ -
Total Current Assets	$ 64,658,842	$ 27,093,007	$ 37,565,836
Noncurrent Assets Who Use Is Limited:			
CHEFA Bond Issue Cost	$ 236,379	$ 236,379	$ -
Investments	$ 26,598,047	$ 26,598,047	$ -
Board Designated Funds	$ -	$ -	$ -
Loans and Other Receivables	$ 262,796	$ 262,796	$ -
Funds Held in Trust by Others	$ 43,411,397	$ 43,411,397	$ -
Goodwill	$ 1,813,567	$ -	$ 1,813,567
Net PP&E	$ 35,691,698	$ 2,056,994	$ 33,634,705
Total Assets	**$ 172,672,727**	**$ 99,658,619**	**$ 73,014,108**
Liabilities			
Current Liabilities			
Accounts Payable and Accrued Expenses	$ (28,992,385.78)	$ (2,828,062)	$ (26,164,323.85)
Current Portion of Accrued Pension Liability	$ (3,867,000)	$ -	$ (3,867,000)
Current Portion of Long Term Debt	$ (2,041,653)	$ (901,423)	$ -
Due to Third-Party Payors	$ (7,759,364)	$ (7,759,364)	$ -
Total Current Liabilities	$ (42,660,402)	$ (11,488,849)	$ (30,031,324)
Long-Term Debt	$ (28,327,258)	$ (24,703,887)	$ (3,623,371)
Other Long-Term Liabilities:			
Workers Compensation	$ (11,601,078)	$ (11,601,078)	$ -
Pension	$ (7,746,917)	$ -	$ (7,746,917)
Malpractice	$ (1,638,066)	$ -	$ (1,638,066)
Asbestos Abatement	$ (2,898,529)	$ -	$ (2,898,529)
Other Long-Term Liabilities	$ (10,819,922)	$ (10,819,922)	$ -
Total Other Liabilities	$ (63,031,770)	$ (47,124,887)	$ (15,906,883)
Total Liabilities	**$ (106,692,172)**	**$ (59,613,736)**	**$ (45,938,207)**
Net Assets	$ 66,980,555	$ 41,044,883	$ 27,075,901
Net Balance Sheet Items	**$ 172,672,727**	**$ 99,658,619**	**$ 73,014,108**

	Cash Accounts	Liquid	Restricted
	$ 22,050,744	$ 20,286,367	$ 1,764,377
	$ 1,496,670	$ 1,298,106	$ 198,564
	$ 26,598,047	$ 14,182,633	$ 12,415,414
	$ -	$ -	$ -
	$ 262,796	$ -	$ 262,796
	$ 43,411,397	$ -	$ 43,411,397
	$ 93,556,653	$ 35,767,106	$ 57,789,752

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

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

Response:

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

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

Response:

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

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

Response:

$2,898,529

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

Response:

CHCA Pension = $27,000,00

Cash Balance Plan = $11,613,917

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

Response:

Approximately $23,700,000 (CHEFA) bonds

$1,700,000 (swap obligations)

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

Response:

SEE ATTACHED AS EXHIBIT Q7G-1

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

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

Response:

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

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

Response:

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

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

Response:

Please see response above.

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

Response:

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

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

Response:

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

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

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

Response:

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

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

Response:

PROSPECT PROVIDER GROUPS, INC.

Chief Executive Officer
Jason Barker

President
Mitchell Lew, M.D.

Chief Financial Officer & Treasurer
Lily Kam

Secretary
Ellen Shin

Senior Vice President
Samuel Lee

Board of Directors
Mitchell Lew, M.D.

PHP HOLDINGS, INC.

Chief Executive Officer, President & Treasurer
Stephen O'Dell

Chief Financial Officer
Brian Werderman

Chief Medical Officer
Arthur Lipper, M.D.

Secretary
Ellen Shin

Senior Vice President
Samuel Lee

Vice President, Compliance
Cheryl Hurst

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

PROSPECT HEALTH SERVICES CT, INC.

Chief Executive Officer
Stephen O'Dell

Chief Financial Officer
Brian Werderman

Secretary
Ellen Shin

Senior Vice President
Samuel S. Lee

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

PROSPECT PROVIDER GROUP CT – WATERBURY, LLC

Chief Executive Officer
Jason Barker

President
Mitchell Lew, M.D.

Chief Financial Officer & Treasurer
Lily Kam

Secretary
Ellen Shin

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

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

Response:

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Discharges:

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

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

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

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

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

Response:

TABLE C
PROJECTED DISCHARGES BY SERVICE

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

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

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

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

Response:

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

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

Response:

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

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

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

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

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

Response:

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

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

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

The payor mix of above hospitals is as follows:

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

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

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

Response:

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

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

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

Response:

TABLE E

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

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

Response:

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

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

Response:

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

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

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

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

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

Response:

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

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

Response:

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

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

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

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

Response:

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

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

Response:

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

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

Response:

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

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

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

Response:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response:

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

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

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

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

Response:

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

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

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

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

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

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

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

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

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

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

Response:

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

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

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

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

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

Response:

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

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

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

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

Response:

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

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

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

TABLE F

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

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

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

Response:

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

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

Response:

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

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

Response:

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

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

Response:

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

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

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

Response:

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

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

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

Response:

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

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

Response:

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

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

Response:

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

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

a) **Waterbury Hospital Infectious Disease Clinic**

Response:

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

b) **Waterbury Health Access Program**

Response:

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

c) Waterbury Hospital Center for Behavioral Health

Response:

DEPARTMENT OF MENTAL HEALTH AND ADDICTIONS GRANTS
FY 15

Acute Inpatient Grant:

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

Crisis Center Grant:

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

DBT/IOP Grant:

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

Adult Outpatient Grant:

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

Homeless Outreach Grant:

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

Outpatient Expansion Grant:

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

Respite Grant:

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

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

d) Be Well Bus

Response:

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

e) Heart Center of Greater Waterbury

Response:

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

f) Family Birthing Center

Response:

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

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

g) Thank God I'm Female

Response:

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

h) Evergreen 50 Club

Response:

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

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

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

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

Response:

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

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

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

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

Response:

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

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

Response:

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

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

Response:

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

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

Response:

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

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

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

Response:

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

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

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

Response:

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

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

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

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

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

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

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

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

Response:

Please see Response to Question 7a.

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

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

Response:

Item # 33a

Greater Waterbury Health Network

	Per CON	Per 2014 Audited F/S	Variance	
Net Patient Revenue	248,588,440	248,939,189	350,749	
Operating Expenses	274,042,856	268,450,195	(5,592,661)	
Net Income (Loss)	(4,678,016)	(4,728,011)	(49,995)	
Net Income:				
Greater Waterbury Management Resources Loss		34,250		
Children's Center of Greater Waterbury Loss		14,787		
		49,037		
		(49,995)		
Audit adjustments made after year end		(958)		
Operating Expenses:				
Waterbury Hospital	227,749,078	216,453,290	(11,295,788)	AMG and CAGW losses
GWIC	2,917,354	2,917,229	(125)	
Access Rehab	10,044,797	10,044,756	(41)	
Imaging Partners	50,694	50,694	-	
AMG	20,799,609	29,103,055	8,303,446	Loss of $8,152,669 plus provision for income taxes of $150,777
CAGW	8,159,105	11,302,221	3,143,116	Loss rolled up to Waterbury Hospital
VNA	4,254,039	4,254,039	-	
GWMR	-	-	-	
Children's Center	-	1,770,632	1,770,632	Not included in CON
GWHN	68,181	69,142	961	Audit Adjustment after year end
Eliminations on Waterbury Hospital F/S	-	(7,456,104)	(7,456,104)	
Eliminations on GWHN F/S	-	(58,759)	(58,759)	
			(5,592,662)	
Net Patient Revenue:				
Waterbury Hospital	208,626,652	208,626,652	-	
GWIC	4,439,791	4,439,666	(125)	
Access Rehab	8,230,315	11,038,847	2,808,532	
Imaging Partners	-	1,691	1,691	
AMG	16,354,898	16,354,899	1	
CAGW	6,397,091	6,397,091	-	
VNA	4,539,692	4,539,692	-	
GWMR	-	-	-	
Children's Center	-	-	-	
GWHN	-	-	-	
Eliminations on Waterbury Hospital F/S		(2,459,349)	(2,459,349)	
			350,750	

Access Rehab Centers:

1,286,157	Income-Contract Services Inpatient	Does not get billed to an insurance
301,920	Income-Contract Mgmt. Services	
1,206,622	Income-Contract Services Outpatient	
13,833	Miscellaneous Income	
2,808,532	Included in Other Operating Revenue on CON	
(82,075)	Lab fees, laundry, rent, etc	
(34,777)	Marketing, rent to AMG	
(1,189)	Rent owed to Access Rehab	
(220,656)	Rehab services billed owed to Access Rehab	
(10,234)	Dividend income	
(2,541)	Mattatuck Medical Investment income	
722	Other Income/Expense	
(350,750)		

For the assumptions, we estimated expenses for FY 2017 and FY 2018 based on general expense assumptions by major category. The losses come from the fact that the renegotiated contracts that generated additional net revenue for FY 2016 will start to level off in the later years of the projections.

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

Response:

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

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

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

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

Response:

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

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

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

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

Response:

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

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

Response:

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

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

Response:

Waterbury Hospital Only	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15	Month of Sep-14	Y-T-D 09/30/14	Month of Sep-15	Y-T-D 09/30/15
A. Operating Performance												
Operating Margin	-1.23%	-0.06%	-18.30%	-3.40%	-3.82%	-0.40%	-10.44%	-4.01%	6.34%	0.18%	-37.26%	-5.91%
Non-Operating Margin	-0.22%	1.40%	-17.22%	-2.20%	-2.41%	1.06%	-9.51%	-2.83%	7.20%	1.59%	-35.16%	-4.68%
Total Margin	-0.19%	1.43%	-17.34%	-2.16%	-2.36%	1.10%	-9.58%	-2.80%	7.27%	1.63%	-38.49%	-4.83%
Bad Debt as % Gross Revenue	3.18%	0.09%	1.09%	0.35%	0.77%	0.15%	0.86%	0.38%	3.19%	0.41%	-0.58%	0.41%
B. Liquidity												
Current Ratio	1.73	1.73	1.53	1.53	1.91	1.91	1.56	1.56	1.70	1.70	1.27	1.27
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66	70.07	70.07	48.2	48.20
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94	47.90	47.9	60.73	60.73
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69	54.38	54.38	58.9	58.90
C. Leverage and Capital Structure												
Long-term Debt to Equity	1.9083	1.9083	-23.7088	-23.7088	2.0337	2.0337	-6.2679	-6.2679	2.1620	2.1620	-2.8563	-2.8563
Long-term Debt to Capitalization	0.6562	0.6562	1.0440	1.0440	0.6704	0.6704	1.1898	1.1898	0.6837	0.6837	1.5387	1.5387
Unrestricted Cash to Debt	0.7582	0.7582	0.3218	0.3218	0.6156	0.6156	0.2694	0.2694	1.0347	1.0347	0.5303	0.5303
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31	1.55	1.55	-10.27	-10.27
Equity Financing Ratio	5.81	5.81	-76.40	-76.40	5.95	5.95	-20.33	-20.33	7.10	7.10	-9.14	-9.14
D. Additional Statistics												
Income from Operations	447,817	6,756,462	(2,301,275)	417,302	4,151	6,760,813	(1,055,931)	(643,631)	1,907,098	8,667,899	(2,987,821)	(3,631,452)
Revenue Over/(Under) Expense	(35,827)	2,588,543	(2,272,128)	(1,707,507)	(416,696)	2,171,848	(1,547,662)	(5,255,169)	1,358,560	4,530,414	(4,350,148)	(9,605,317)
Patient Cash Collected	16,953,790	173,216,936	17,588,030	165,780,926	16,391,215	189,608,151	16,367,950	182,148,876	19,856,343	209,464,494	17,283,378	199,432,254
Cash and Cash Equivalents	20,457,074	20,457,074	8,257,373	8,257,373	16,563,273	16,563,273	6,880,235	6,880,235	27,540,854	27,540,854	16,284,244	16,284,244
Net Working Capital	22,842,265	22,842,265	15,242,354	15,242,354	25,043,856	25,043,856	16,052,250	16,052,250	24,599,297	24,599,297	10,506,595	10,506,595
Unrestricted Assets	13,704,068	13,704,068	(1,045,742)	(1,045,742)	12,825,022	12,825,022	(3,936,749)	(3,936,749)	11,890,055	11,890,055	(10,064,752)	(10,064,752)
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Total GWHN	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15	Month of Sep-14	Y-T-D 09/30/14	Month of Sep-15	Y-T-D 09/30/15
A. Operating Performance												
Operating Margin	-4.04%	-3.03%	-20.71%	-6.77%	-6.81%	-3.31%	-14.10%	-7.39%	-3.34%	-3.31%	-37.39%	-9.24%
Non-Operating Margin	-3.17%	-1.80%	-19.90%	-5.81%	-5.61%	-2.12%	-13.35%	-6.45%	-2.61%	-2.16%	-35.83%	-8.26%
Total Margin	-3.72%	-1.62%	-19.53%	-5.97%	-4.63%	-1.88%	-15.30%	-6.77%	-4.02%	-2.06%	-38.92%	-8.75%
Bad Debt as % Gross Revenue	-2.80%	0.16%	1.02%	0.39%	0.79%	0.21%	0.85%	0.43%	2.98%	0.45%	0.61%	0.45%
B. Liquidity												
Current Ratio	1.68	1.68	0.97	0.97	1.79	1.79	1.03	1.03	1.60	1.60	1.17	1.17
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66	70.07	70.07	48.20	48.20
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94	47.90	47.90	60.73	60.73
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69	54.38	54.38	58.90	58.90
C. Leverage and Capital Structure												
Long-term Debt to Equity	0.7431	0.7431	1.5119	1.5119	0.7707	0.7707	1.8978	1.8978	0.8045	0.8045	4.38	4.38
Long-term Debt to Capitalization	0.4263	0.4263	0.6019	0.6019	0.4353	0.4353	0.6549	0.6549	0.4458	0.4458	0.81	0.81
Unrestricted Cash to Debt	1.0410	1.0410	0.1171	0.1171	0.8984	0.8984	0.1166	0.1166	1.3397	1.3397	0.80	0.80
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31	1.55	1.55	-10.27	-10.27
Equity Financing Ratio	2.38	2.38	5.16	5.16	2.40	2.40	6.56	6.56	2.83	2.83	14.85	14.85
D. Additional Statistics												
Income from Operations	(178,926)	1,025,260	(3,486,774)	(7,575,080)	(705,922)	402,465	(2,119,606)	(9,694,688)	42,986	445,460	(8,454,655)	(18,149,342)
Revenue Over/(Under) Expense	(868,438)	(3,603,719)	(3,946,434)	(12,862,636)	(1,002,893)	(4,581,472)	(3,064,172)	(15,926,812)	(892,841)	(5,474,307)	(8,022,874)	(21,949,687)
Patient Cash Collected	20,638,288	208,125,604	21,041,111	200,383,967	19,923,196	228,048,799	19,137,425	219,521,392	22,806,351	250,855,150	20,336,820	239,559,240
Cash and Cash Equivalents	28,151,297	28,151,297	3,010,785	3,010,785	24,214,495	24,214,495	2,978,798	2,978,798	35,766,184	35,766,184	24,493,383	24,493,383
Net Working Capital	23,732,718	23,732,718	(1,022,164)	(1,022,164)	25,115,685	25,115,685	1,012,991	1,012,991	24,644,118	24,644,118	7,573,582	7,573,582
Unrestricted Assets	35,190,459	35,190,459	16,435,945	16,435,945	33,840,369	33,840,369	13,002,038	13,002,038	31,996,355	31,996,355	6,572,339	6,572,339
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

Response:

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

OAG Questions

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

Response:

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

(a) the healthcare needs of the Communities;

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

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

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

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

Response:

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

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

Response:

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

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

Response:

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

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

EXHIBIT Q7G-1

GWHH Reminder Hospital
Expected Remaining Cash Balances
Updated October 20, 2015 with 9/30/15 Net Proceeds Analysis
Years 1 through 10 Post Close

			Pre-Closing	Post-Closing	Post-Closing										
		9/30/2015	1st 6 Months FY 2016	Last 6 Months FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	Totals	
Sales Price		25,000,000														
Target Working Capital @ 9/30/15		6,800,000														
Capital Lease Allowance	Estimated @ 9/30/15	0														
Total Purchase Price		31,800,000														
Less: Certain Liabilities Assumed by Joint Venture																
Nurses Pension	CHCA Pension Shortfall	(27,000,000)														
Non Union Pension	As of 9/30/15	(11,642,917)														
Asbestos Liability	As of 9/30/15	(2,668,579)														
Capital Lease Debt Assumed by Prospect	As of 9/30/15	0														
Net Enterprise Value		(9,712,496)														
Net Working Capital Adjustment ($11,401,512-$6,800,000)		4,601,512														
Cash proceeds to GWHH Before Expenses		(5,110,984)														
Less: Foundation Expenses																
FTC Counsel	Estimate	(50,000)														
Estimated Advisor Fees	Banker $800k Legal $600k	(1,400,000)														
Malpractice LPT and Tail (net of Captive Assets)	Assumed by Prospect	0														
Contingency		-														
Gross Cash Proceeds to "Older"		(6,560,934)														
Net Proceeds of Sale		(6,560,934)														
Gross Unrestricted Liquid Cash On Books at Closing @ 9/30/15	36,767,166															
Less: Immediate Payoff Of Certain Retained Liabilities																
CHEFA Debt	(23,788,744)	Per books 9/30/15														
CHEFA Interest Rate Swap	(1,512,596)	Per books 9/30/15														
Other Long Term Debt Debt	(904,894)	Assumed by Prospect														
	(26,206,234)															
Net Unrestricted Liquid Cash On Books At Closing After Payoff		10,560,932														
Estimated Remaining Cash @ 9/30/15		3,568,938														
Sources of Cash																
Projected Annual Unrestricted Endowment Income (exclude Holman $19.2M)		(4/5ths) (5/6ths)	900,000	900,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	19,800,000	
FY13 Medicare Cost Report		$543,606 recd in May '14, bal expected in FY16	225,801		0										225,801	
FY14 Medicaid Cost Report		To be Paid 2Q'15			7,377										7,377	
FY 14 Medicare Cost Report		estimated @9/30/14		(66,264)											(66,264)	
Workers Comp A/R Claims Settlement Fairpay		To be recd 12/15	712,000												712,000	
DSH Receivable FY 2015		File in 2016	0	550,000											550,000	
Recoup of Use Money related to FY 2014 & 2015 Hospital (Core and Cash)		As of 9/30/15	322,659		0										322,659	
Cancer Center Distribution		To be received in Dec '15	750,000	0											750,000	
FY 2015 Medicaid 10/1/14 to 12/31/14			0	(157,190)											(157,190)	
Estimated Investment Earnings		2.0% of annual avg cash	41,046	37,068	36,159	(24,447)	(51,134)	(54,735)	(49,659)	(40,221)	(28,663)	(14,676)	1,140	19,093	(156,291)	
Total Sources of Cash			2,951,529	1,263,806	1,843,536	1,775,553	1,748,866	1,745,265	1,750,659	1,759,779	1,771,337	1,785,324	1,801,140	1,819,093	21,905,308	21,905,308
Uses of Cash																
State of CT Dual Eligible Takeback			305,044												305,044	
Operating Losses 10/1/15 to 3/31/16		Includes $0.2M of Taxes	1,514,057												1,514,057	
Estimated RAC Payouts (Net of Recoveries)		Avg. paid three years		250,000	500,000	500,000	500,000								1,750,000	
FY 2012 Medicare Cost Report Settlement-MU		As of 9/30/14	0	0											-	
Medicaid OP claim audit for 2010 to 2012		Completed	0	0											-	
Potential State reprocessing of SFY 2014 OP claims		estimated @ 9/30/14		0											-	
FY 2011 Medicare Cost Report Settlement-Revised Cost Report		As of 9/30/14	0	0											-	
State of CT Sales Tax Payment for 1/1/16 to 3/31/16		Payable April, 2016	0		-										-	
Medicaid Outpatient audits (7/1/12 to 6/30/14)(7/1/14-3/31/15)		Based on most recent			1,400,000	1,225,000	0	0	0	0	0	0	0	0	2,625,000	
Medicaid ROC Recoupment		Accrued 9/30/15		1,410,000	-	0	0	0	0	0	0	0	0	0	1,410,000	
Subtotal			1,819,101	1,660,000	1,900,000	1,725,000	500,000	0	0	0	0	0	0	0	7,664,101	7,664,101

Other Foundation Expenses														
Cost of managing the Foundation	.5 FTE Exec Dir.	0	0	117,000	117,000	117,000	117,000	117,000	117,000	117,000	117,000	117,000	117,000	1,170,000
Services Purchased from Prospect	Site separate w/s	0	0	33,000	33,000	33,000	0	0	0	0	0	0	0	99,000
Insurance	Site separate w/s	0	0	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	260,000
Dr Harris Center Subsidy	Decided current subsidy	0	0	-	-	-	-	-	-	-	-	-	-	-
Health and Dental Claims Runout	I&R Per Actuary	0	0	-	0	0	0	0	0	0	0	0	0	-
Payment Above Funding of CHCA Withdrawal Liability	Per tentative settlement	0	0	0	0	0	0	0	0	0	0	0	0	-
Subtotal Other Foundation Expenses		-	-	143,000	150,000	143,000	143,000	143,000	143,000	143,000	143,000	143,000	143,000	1,569,000	1,580,000
Workers Comp Costs														
Claims Payments (from actuary rep't	From 9/30/15 actuary rep	-	1,366,183	2,314,713	1,647,092	1,259,692	1,009,264	912,259	911,291	559,497	911,644	527,158	456,486	11,845,520	
State of CT 2nd injury Fund	(.858% of paid claims	-	70,681	124,134	50,809	72,770	63,763	53,556	47,626	40,824	36,787	31,572	25,992	669,045	
Excess Policy Premium	Will not need		0	0	0	0	0	0	0	0	0	0	0	-	
Fees for legal, C of C, Actuary, TPA	Site separate w/s		0	256,500	231,500	181,500	181,500	181,500	181,500	106,500	106,500	106,500	106,500	1,663,000	
Subtotal Workers Comp Costs		-	1,444,864	2,695,347	1,929,311	1,493,962	1,254,527	1,147,315	1,140,417	706,821	1,054,931	665,230	588,978	14,177,565	13,892,571
Certain Fees														
Fees for Memos (Investment Consulting)	To be negotiated	0		-	-	-	-	-	-	-	-	-	-	-	
Fees for ERP (Investments)	to be negotiated	0		-	-	-	-	-	-	-	-	-	-	-	
Accounting and Auditing	Per separate w/s	0		100,000	75,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	575,000	
Legal Fees	Estimated	0		100,000	50,000	50,000	25,000	20,000	10,000	10,000	10,000	10,000	10,000	295,000	
Contract Cancelation Fees	Estimated	0		-	-	0	-	0	0	0	0	0	0	-	
Subtotal Certain Fees		0	-	200,000	125,000	100,000	75,000	70,000	60,000	60,000	60,000	60,000	60,000	870,000	900,000
Liquidation of 9/30/14 Liabilities														
Repayment of Children's Center CHEFA Debt			752	9,840	9,840	10,650	10,600	11,450	13,612	13,612	13,612	13,612	13,612	121,257	
Repayment of Children's Center A/P	Not required	0	0	0	0	0	0	0	0	0	0	0	0	0	
HMO Capital Call	Repaid April 2014	0	0	0	0	0	0	0	0	0	0	0	0	0	
Medicaid Overstated Repayment (cost to charge ratio)	Accepted not included 2013	0	0	0	0	0	0	0	0	0	0	0	0	0	
Repayment of FY 2012 Medicare Cost Report	check out 12/31/15	0	0	0	0	0	0	0	0	0	0	0	0	0	
Repayment of 2013 ERA Payable	to be repaid starting 2014	0	0	0	0	0	0	0	0	0	0	0	0	-	
Repayment of 2014 ERA Payable	to be repaid after 2014	0	0	0	0	0	0	0	0	0	0	0	0	-	
Intentionally Left Blank		0	0	0	0	0	0	0	0	0	0	0	0	-	
Subtotal of 9/30/14 Liabilities		-	752	9,840	9,840	10,650	10,600	11,450	13,612	13,612	13,612	13,612	13,612	121,257	121,257
Total Uses of Cash		1,599,101	3,104,806	4,768,187	3,923,151	3,297,837	3,050,177	3,361,925	3,259,058	3,101,430	3,457,329	951,829	844,143	29,139,964	
Net change in Cash		1,052,449	(1,848,808)	(2,664,058)	(2,148,588)	(548,758)	165,068	388,045	592,781	864,005	749,160	849,385	876,053	2,144,659	
Estimated Cash On Hand End of Year		4,651,357	2,802,557	101,299	(2,307,597)	(2,856,845)	(2,671,503)	(2,283,515)	(1,776,004)	(1,115,199)	(367,039)	482,210	1,457,262	1,457,262	
Minimum Required PPV Agreement		0	0	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	0	0	0	0	0		
Excess/(Deficiency)		4,651,357	2,802,557	(4,401,299)	(6,807,597)	(7,356,845)	(7,171,503)	(6,783,515)	(1,776,004)	(1,115,199)	(367,039)	482,210	1,457,262	1,457,262	
Ending Cash Balance Before Investment Income		4,619,911	2,765,269	(197,452)	(2,280,444)	(2,809,514)	(2,696,605)	(2,233,468)	(1,730,503)	(1,088,534)	(353,421)	461,670	1,438,026		
Average Cash On Hand		4,635,634	2,783,913	1,509,557	(1,022,509)	(2,555,201)	(2,736,756)	(2,458,512)	(2,041,045)	(1,451,169)	(730,609)	55,661	950,148		
Investment Income (assumes 2.0% annual interest)		41,046	37,648	29,158	(23,447)	(51,134)	(54,735)	(49,170)	(40,821)	(29,023)	(14,616)	1,140	19,003		

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, January 12, 2016 4:02 PM
To: Greer, Leslie
Subject: FW: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. application filed under Docket Numbers: 15-32017-486 and 15-486-02
Attachments: 15-32017-486 and 15-486-02 2nd OHCA Questions_1_12_16_GWHN.docx; 15-32017-486 and 15-486-02 Second Completeness Letter.pdf

Please add to the original record.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Lazarus, Steven
Sent: Tuesday, January 12, 2016 3:27 PM
To: Ann H. Zucker; Michele Volpe (mmv@bvmlaw.com)
Cc: Hawes, Gary W.; Martone, Kim; Hansted, Kevin; Riggott, Kaila; Cotto, Carmen
Subject: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. application filed under Docket Numbers: 15-32017-486 and 15-486-02

Good Afternoon,

Please see the attached *Second* Completeness Letter for the above referenced proposal filed with the Office of the Attorney General and The office of Health Care Access (Department of Public Health). If you have any □uestions, please do not hesitate to contact Gary Hawes or myself (contact information provided in the Completeness Letter).

Please **confirm receipt** of this email and documentation.

Sincerely,

Steven

Ps. Attached files include the actual signed PDF copies, as well as the electronic copy in Word for your convenience.

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
ACTING COMMISSIONER

January 12, 2016

VIA U.S. and ELECTRONIC MAIL
Darlene Stromstad, FACHE
President/CEO
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06708

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02

Dear Ms. Stromstad and Mr. Spees:

On December 24, 2015, the Response to Completeness Questions ("Response") of Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH") was filed with the Office of Health Care Access, Department of Public Health ("OHCA/DPH") and Office of the Attorney General ("OAG").

OHCA/DPH have determined that there are deficiencies in the Response that require clarification and/or additional production. Conn. Gen. Stat. § 19a-486a(d). The OAG has no further questions at this time. Accordingly, please respond to the following questions and/or submit the following materials to the OAG and OHCA by February 1, 2016.

1. Reference is made to the April 1, 2014 Statement of Deficiencies report of surveyors from the California Department of Public Health following a Full Sampled Validation Survey of Southern California Hospital at Hollywood ("Initial Report") and the August 21, 2014 Statement

of Deficiencies report of the agency following a Follow-up Visit to the same facility ("Follow-up Report"). These reports were provided as Exhibit P to PMH's and ECHN's Response to Deficiencies dated October 30, 2015 and November 12, 2015 under OHCA Docket No. 15-31216-486 and OAG Docket No. 15-486-01, and the page numbers referenced in this Question #1 refer to that submission. In both reports the surveyors determined Immediate Jeopardy situations to exist. With respect to these reports, please address the following:

a. In the Initial Report, the surveyors determined that Southern California Hospital at Hollywood (the "Hospital") failed to meet the CMS Conditions of Participation in the following areas: Governing Body; Patient Rights; Nursing Services; Pharmaceutical Services; Food and Dietetic Services; Physical Environment; Infection Control; and Surgical Services. On page 2836, the Initial Report states that the Governing Body failed to provide oversight of operations in each of the other areas. Please explain how a situation where Condition Level deficiencies in eight separate areas came to exist at the Hospital, the accountability of both the Hospital's and PMH's senior management for allowing such a situation to exist, and steps taken at the PMH system level to rectify the situation.

b. In the Follow-up Report, the surveyors found Condition Level deficiencies still existed in that the Hospital failed to develop, implement, and maintain an effective quality assurance and performance improvement (QAPI) program (p. 2686 *et seq.*); failed to provide a sanitary environment to avoid sources and transmissions of infections and communicable diseases (p. 2764 *et seq.*), and found a repeat violation as to the acceptability of surgical services (p. 2788 *et seq.*). Please explain the accountability of both the Hospital's and PMH's senior management for allowing such a situation to exist and steps taken at the PMH system level to rectify the situation.

c. Please identify and provide the Statement of Deficiencies reports for any other instances where PMH owned hospitals have been determined to have Immediate Jeopardy situations during the term of PMH's ownership.

d. With respect to all Immediate Jeopardy determinations identified in Question 1a, b and c above, please describe all system-wide improvements (including system-wide policies and procedures), management reporting, business strategies and/or changes in culture that have been put into place to prevent recurrence of such situations. PMH is requested to provide documentation of any system-wide communications evidencing these prevention activities.

2. In response to Question 15, Applicants refer to PMH's participation in the Private Essential Access Community Hospitals ("PEACH") network as evidence of PMH's experience with "safety net" hospitals that serve low-income patients. Please elaborate on how PMH's experience and participation in the PEACH network in California will translate into improved access to quality care for underserved populations in Waterbury and its surrounding areas. In

your response, please highlight specific programs, insights, or innovations PMH has acquired through participation in PEACH that PMH expects to apply to PMH-owned "safety net" hospitals in Connecticut.

3. In response to Question 20, Applicants summarize PMH's medical management program for high risk patients with significant co-morbidities in a sub-acute setting. Please elaborate on the following:

a. What types of facilities comprise sub-acute settings and how many facilities of this type does PMH own, operate or manage?

b. What is the relationship of the physicians and nurse practitioners performing the rounding on high-risk patients in these settings to PMH?

c. How does PMH assure that rounding on the frequency mentioned (2-5x per week) is completed in sub-acute settings that it does not own, operate or manage?

4. In reference to the response to Question 23, please clarify why the change in charity care policy at Waterbury Hospital in October 2013 wherein patients who do not apply for or do not qualify for charity care are responsible for the balance due would result in an increase in charity care and a decrease in bad debt in FY2014 as opposed to an increase in bad debt alone.

5. In reference to Applicants' answer to Question 34 of the Response, the Applicants failed to provide the requested updated Financial Measurements/Indicators for the months of July, August and September 2015 and comparable months from the previous fiscal year for PMH, the methodology utilized to calculate the financial ratios on Sections A through C and an explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015. Please provide the requested information.

6. In reference to the Applicants' answer to Question 33 of the Response, please address the following:

a. In response to question 33(b) the Applicants indicated that *"The non-governmental net revenue by specific payers is not usually finalized until the OHCA filing is completed, so we do not have the FY 2015 final net revenue by specific payer (with allocation of charity care, bad debts, etc.)"*, hence the zero incremental amounts reported under the uninsured, self-pay and workers compensation line items.

The amounts requested on Financial Worksheet (C) by OHCA are FY 2014 actual and projected amounts with, without and incremental associated with the proposal for FY 2015 and thereafter. Therefore, please provide a revised Financial Worksheet (C) for Waterbury Hospital that will include FY 2014 actual

amounts and projected amounts for FYs 2015, and thereafter, for the uninsured, self-pay and workers compensation line items. In addition, include projected incremental amounts associated with the proposal that relates to expense items, operating income, non-operating revenue and net income. Provide the missing assumptions utilized in developing the projections and explain any projected losses from operations; and

b. In responding to question 33(d) the Applicants explained the expected reduction in expenses for FY 2016 but failed to explain the incremental increases in expenses as the result of this proposal for FYs 2017 and 2018. Please provide the requested information.

7. In Applicants' answer to Question 19 of the Response, Applicants state that PMH has *"[p]roposed a pilot program in the state of Rhode Island to manage the health of 25,000 Medicaid patients at a cost savings to the state of Rhode Island" and that "PMH is prepared to work with the state of Connecticut on a similar proposal to manage a segment of the Medicaid population in Connecticut at cost savings to the State."* Please provide the name of the proposed Rhode Island program and a detailed description of the program and how it will achieve Medicaid savings. Include in your response the cost of implementation and projected cost savings associated with the program.

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

After receipt of these requested materials, the OAG and OHCA shall review the submission to determine whether the application for approval is complete. If not, they shall provide written notice of any deficiencies within twenty (20) days of receipt of the information requested. Should you have any questions regarding these requests or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General
Office of the Attorney General

Very truly yours,

Kimberly R. Martone
Director of Operations
Office of Health Care Access

cc: Steven Lazarus (via electronic mail)
Ann Zucker, Esq.
Michelle Volpe, Esq.

Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, January 20, 2016 9:36 AM
To: Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); magsten@wiggin.com; Ann H. Zucker; Michele Volpe (mmv@bvmlaw.com)
Cc: Hawes, Gary W.; Martone, Kim; Hansted, Kevin; Riggott, Kaila; Cotto, Carmen; Greer, Leslie
Subject: Re: Docket Numbers: 15-32016-486/15-486-01 and 15-32017-486 and 15-486-02 Administrative Notices
Attachments: 15-32016-486 and 15-486-01 Administrative Notice (ECHN).pdf; 15-32017-486 and 15-486-02 Administrative Notice (Waterbury).pdf

Good Morning,

Please see the attached Administrative Notices for Eastern Connecticut Health Network, Inc. and Greater Waterbury Health Network, Inc.'s proposals involving Prospect Medical Holdings, Inc. filed under the above referenced docket numbers. If you have any questions regarding this matter, please feel free to contact Gary Hawes (gary.hawes@ct.gov) or myself.

Sincerely,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
ACTING COMMISSIONER

Docket Nos.: OHCA 15-32017-486
OAG 15-486-02

In re: Greater Waterbury Health Network, Inc., and Prospect Medical Holdings, Inc.

January 20, 2016

ORDER REGARDING ADMINISTRATIVE NOTICE

The Office of Health Care Access and the Office of the Attorney General are hereby taking administrative notice of the record in ***In re: Eastern Connecticut Health Network, Inc., and Prospect Medical Holdings, Inc.***, Docket Nos. OHCA 15-32016-486 and OAG 15-486-01 for purposes of processing the Application filed in ***In re: Greater Waterbury Health Network, Inc., and Prospect Medical Holdings, Inc.***, Docket Nos. OHCA 15-32017-486 and OAG 15-486-02.

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, February 16, 2016 1:22 PM
To: Greer, Leslie
Subject: FW: Greater Waterbury Health Network, Inc./Prospect Medical Holdings, Inc.
Attachments: N5183091.PDF

Please add to the record.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Anne D. Peterson [mailto:APeterson@carmodylaw.com]
Sent: Tuesday, February 16, 2016 1:19 PM
To: Lazarus, Steven; Hawes, Gary W.; Martone, Kim
Cc: dstromstad@wtbyhosp.org; Jonathan.Spees@prospectmedical.com; Ann H. Zucker; mmv@bvmlaw.com
Subject: Greater Waterbury Health Network, Inc./Prospect Medical Holdings, Inc.

Dear Mr. Lazarus, Mr. Hawes and Ms. Martone:

Attached please find Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. responses to the completeness questions issued by the Office of the Attorney General and the Office of Health Care Access on January 12, 2016. Electronic and paper copies will be hand delivered this afternoon. Thank you for your consideration.

Anne D. Peterson

Anne D. Peterson | Bio
Carmody Torrance Sandak & Hennessey LLP
195 Church Street | P.O. Box 1950
New Haven, CT 06509-1950
Direct: 203-784-3104 | Fax: 203-784-3199
APeterson@carmodylaw.com www.carmodylaw.com

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Ann H. Zucker
Partner
Direct: 203.252.2652
Fax: 203.325.8608
azucker@carmodylaw.com

707 Summer Street
Stamford, CT 06901

February 16, 2016

VIA HAND DELIVERY

Office of the Attorney General
55 Elm St.
P.O. Box 120
Hartford, CT 06141-0120
Attn: Atty. Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capital Avenue
Hartford, CT 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02

Dear Mr. Hawes and Mr. Lazarus:

Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. hereby submit the enclosed responses to the completeness questions issued by the Office of the Attorney General and the Office of Health Care Access on January 12, 2016.

At your request, one (1) hard copy and (1) electronic copy have been provided to each Office. If you have any questions or need anything further, please feel free to contact Ann Zucker at (203) 252-2652 or Michele Volpe at (203) 777-6995. Thank you for your assistance in this matter.

(N5167586)

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Very truly yours,

Carmody Torrance Sandak & Hennessey LLP

By: _____
Ann H. Zucker
Its Partner

Bershtein Volpe & McKeon, P.C.

By: _____
Michele Volpe
Its Partner

cc. Kimberly Martone, Director of Operations, Department of Public Health
Division of Office of Health Care Access
Jonathan Spees, Prospect Medical Holdings, Inc. (via regular mail)
Darlene Stromstad, Greater Waterbury Health Network, Inc. (via regular mail)

On January 12, 2016, Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH" and, together with GWHN, the "Applicants"), received correspondence from the Office of the Attorney General ("OAG") and the Office of Health Care Access ("OHCA") requesting additional clarification for certain deficiencies identified in the Application submitted on October 28, 2015, and the Response to Deficiencies submitted on December 24, 2015. The Applicants' Response to these deficiencies is provided below.

1. Reference is made to the April 1, 2014 Statement of Deficiencies report of surveyors from the California Department of Public Health following a Full Sampled Validation Survey of Southern California Hospital at Hollywood ("Initial Report") and the August 21, 2014 Statement of Deficiencies report of the agency following a Follow-up Visit to the same facility ("Follow-up Report"). These reports were provided as Exhibit P to PMH's and ECHN's Response to Deficiencies dated October 30, 2015 and November 12, 2015 under OHCA Docket No. 15-31216-486 and OAG Docket No. 15-486-01, and the page numbers referenced in this Question #1 refer to that submission. In both reports the surveyors determined Immediate Jeopardy situations to exist. With respect to these reports, please address the following:

a. In the Initial Report, the surveyors determined that Southern California Hospital at Hollywood (the "Hospital") failed to meet the CMS Conditions of Participation in the following areas: Governing Body; Patient Rights; Nursing Services; Pharmaceutical Services; Food and Dietetic Services; Physical Environment; Infection Control; and Surgical Services. On page 2836, the Initial Report states that the Governing Body failed to provide oversight of operations in each of the other areas. Please explain how a situation where Condition Level deficiencies in eight separate areas came to exist at the Hospital, the accountability of both the Hospital's and PMH's senior management for allowing such a situation to exist, and steps taken at the PMH system level to rectify the situation.

Response:

PMH is committed to providing the highest quality healthcare to patients in the communities we serve. As previously provided in our CON filing, we have received a substantial number of quality awards and we continuously strive to make improvements in our quality programs at a local level.

Partly in response to the Statement of Deficiencies received in 2014 and partly due to events in late 2015 and early 2016, PMH has created and hired for the following three new positions at the corporate level: (i) Chief Clinical Officer; (ii) Senior Chief Nursing Officer; and (iii) Vice President of Regulatory and Patient Safety. PMH is also currently recruiting for, and is currently seeking to fill a new position of Chief Quality Officer. The roles of these new officers are to interact with local boards and local leadership on continuous basis to ensure safety, adherence to regulatory requirements, clinical excellence and patient satisfaction at all PMH hospitals and to closely monitor execution of plans of correction in response to any issue raised in surveys by regulatory authorities responsible for quality.

It will also be the responsibility of these new officers and their staffs to identify issues early and communicate them to PMH corporate so that we may address such issues quickly and efficiently. It will also be the responsibility of the new officers to marshal corporate resources to address all of the above

areas. An example of this "resourcing" is the engagement of a nationally recognized consulting firm described below.

At the local level, direct responsibility for the quality programs for each PMH hospital is administered by hospital leadership so that any and all quality issues raised by physicians and/or staff are timely addressed and quickly resolved. Oversight of the local leadership is provided by, and is the responsibility of, PMH's senior management. The Quality Assurance and Performance Improvement Plan at Southern California Hospital at Hollywood (the "Hospital") are overseen by a local advisory governing board and the Medical Executive Committee (the "MEC").

While not intended to be exculpatory, a brief history of the Hospital will help explain the contributing factors that led to the Statement of Deficiencies.

Prior to January 1, 2013, the licensure of Hollywood Community Hospital included the Van Nuys campus, therefore constituting a two campus license for state licensure and Medicare purposes. On January 1, 2013, Hollywood Community Hospital's license was amended to merge with Brotman Hospital's license (previously a standalone facility), thereby creating a three campus license. As a result of this license consolidation, the legal names of the hospitals were changed to Southern California Healthcare System, Inc. d/b/a Southern California Hospital at Hollywood, Southern California Hospital at Culver City and Southern California Hospital at Van Nuys.

The license consolidation necessitated the implementation of new policies and procedures across all three campuses. Essentially, the policies and procedures of the new 3 campus system were to be the amalgamation of the best practices of these campuses prior to the consolidation.

Hospital leadership failed to adequately ensure that these new policies and procedures which were adopted by the board were implemented and that the staff educated on the new policies and procedures, and that adherence to such policies was monitored. In part, because of such failure PMH made executive-level changes at key positions including, the CEO, CNO and Director of Quality Management. A by-product and an unintended consequence of the turnover at these key positions resulted in temporary problems with change management and leadership in such areas resulting in the Deficiencies and poor communication to PMH corporate regarding such issues.

At the local hospital leadership level, these key positions are now filled by strong experienced leaders. In addition, PMH has hired a nationally recognized consulting firm to conduct a review of the Hospital's action plan and policies and procedures. To the extent necessary, policies and procedures will be updated to reflect the best practices given the services provided by the Hospital at each campus. The consulting firm will educate the staff on all policies and procedures and implement corrective action plans. Furthermore, for a period of time, the consulting firm will also monitor the adherence of the staff to the policies and procedures.

b. In the Follow-up Report, the surveyors found Condition Level deficiencies still existed in that the Hospital failed to develop, implement, and maintain an effective quality assurance and performance improvement (QAPI) program (p. 2686 *et seq*.); failed to provide a sanitary environment to avoid sources and transmissions of infections and communicable diseases (p. 2764 *et seq*.), and found a repeat violation as to the

acceptability of surgical services (p. 2788 *et seq*.). Please explain the accountability of both the Hospital's and PMH's senior management for allowing such a situation to exist and steps taken at the PMH system level to rectify the situation.

Response:

For the list of steps please refer to response to Questions 1a.

c. Please identify and provide the Statement of Deficiencies reports for any other instances where PMH owned hospitals have been determined to have Immediate Jeopardy situations during the term of PMH's ownership.

Response:

All issues related to the 2014 Statement of Deficiencies were resolved. However, in late 2015 and 2016, additional Immediate Jeopardy deficiencies were noted for Los Angeles Community Hospital and Southern California Hospital at Culver City. The deficiency giving rise to Immediate Jeopardy status at Los Angeles Community Hospital is set forth in Exhibit Q1c-1 attached hereto. One deficiency giving rise to Immediate Jeopardy Status in Southern California Hospital at Culver City relates to the hospital's process in sterilization and infection control, and is set forth in Exhibit Q1c-2 attached hereto. The hospital was orally informed of the deficiency and resulting Immediate Jeopardy status, but the hospital has not yet formally received a written notice from CMS. PHM believes that the third Immediate Jeopardy notice (although not yet received), involves essentially the issues described in Exhibit Q1c-2. Since receiving the written notice at Los Angeles Community Hospital and oral notices at Southern California Hospital at Culver City, PMH has been closely working with the Center for Medicare and Medicaid Services. On February 9, 2016, Los Angeles Community Hospital submitted its plan of correction, and in anticipation of receipt of an Immediate Jeopardy citation for Southern California Hospital at Culver City is in the process of correcting these deficiencies and will provide evidence of same in a plan of correction once it receives a formal written notice.

d. With respect to all Immediate Jeopardy determinations identified in Question 1a, b and c above, please describe all system-wide improvements (including system-wide policies and procedures), management reporting, business strategies and/or changes in culture that have been put into place to prevent recurrence of such situations. PMH is requested to provide documentation of any system-wide communications evidencing these prevention activities.

Response:

For the list of steps please refer to response to Question 1a.

2. **In response to Question 15, Applicants refer to PMH's participation in the Private Essential Access Community Hospitals ("PEACH") network as evidence of PMH's experience with "safety net" hospitals that serve low-income patients. Please elaborate on how PMH's experience and participation in the PEACH network in California will translate into improved access to quality care for underserved populations in Waterbury and its surrounding areas. In your response, please highlight**

specific programs, insights, or innovations PMH has acquired through participation in PEACH that PMH expects to apply to PMH-owned "safety net" hospitals in Connecticut.

Response:

PEACH is the statewide association of California's private community safety net hospitals that care for significant numbers of low-income, medically vulnerable Californians. Member hospitals are core safety net providers that devote at least 25 percent of their revenues to care for low-income and uninsured patients. PMH participation in PEACH was meant as evidence of our commitment to serve low-income patients. A number of PMH's California hospitals devote at least 25% of their revenues for care of low income patients.

Please note that PEACH is committed to preserving private safety net hospitals through the advocacy of public policy at the local, state and federal level. As such, it does not generate any specific programs or innovations that improve quality of care.

3. **In response to Question 20, Applicants summarize PMH's medical management program for high risk patients with significant co-morbidities in a sub-acute setting. Please elaborate on the following:**

a. What types of facilities comprise sub-acute settings and how many facilities of this type does PMH own, operate or manage?

Response:

Sub-acute care is a level of care needed by a patient who does not require hospital acute care. Sub-acute patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. PMH also considers a skilled nursing facility as a sub-acute setting.

In its California hospitals, PMH operates 59 licensed sub-acute beds. PMH also operates a 42 bed pediatric sub-acute unit at Foothill Regional Medical Center in California.

PMH also has an 85% ownership interest in and operates a 194 bed skilled nursing facility in Rhode Island.

b. What is the relationship of the physicians and nurse practitioners performing the rounding on high-risk patients in these settings to PMH?

Response:

The physicians and nurse practitioners rounding in sub-acute facilities are generally contracted with Prospect IPAs.

c. How does PMH assure that rounding on the frequency mentioned (2-5x per week) is completed in sub-acute settings that it does not own, operate or manage?

Response:

The Prospect IPA oversees the frequency of provider rounding, the care plans for patients, and a patient's progress toward discharge goals. A medical director and a case manager employed or contracted by Prospect IPA conduct phone rounds with the facilities to ensure the execution of the care plans, rounding and progress towards discharge. The IPA case manager tracks any issues with either the providers or facilities, in order to perform on-going quality and performance improvement.

4. **In reference to the response to Question 23, please clarify why the change in charity care policy at Waterbury Hospital in October 2013 wherein patients who do not apply for or do not qualify for charity care are responsible for the balance due would result in an increase in charity care and a decrease in bad debt in FY2014 as opposed to an increase in bad debt alone.**

Response:

It is Waterbury Hospital's policy to write down the balance due for patients without insurance to 50% of billed charges. Per the charity care policy, patients who are uninsured are expected to pay 50% of the balance due. This would be the amount for which they would receive a bill for and payment expected, and any portion of this billed balance that is not paid would be classified as bad debt. Based on the policy, this original 50% write-down of charges is considered charity care, under the policy.

5. **In reference to Applicants' answer to Question 34 of the Response, the Applicants failed to provide the requested updated Financial Measurements/Indicators for the months of July, August and September 2015 and comparable months from the previous fiscal year for PMH, the methodology utilized to calculate the financial ratios on Sections A through C and an explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015. Please provide the requested information.**

Response:

PMH:

Please see attached Exhibit Q5-1.

GWHN: [1]

Waterbury Hospital Only	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15	Month of Sep-14	Y-T-D 09/30/14	Month of Sep-15	Y-T-D 09/30/15
A. Operating Performance												
Operating Margin	-1.23%	-0.06%	-18.30%	-3.40%	-3.87%	-0.40%	-10.44%	-4.01%	6.34%	0.18%	-37.28%	-5.91%
Non-Operating Margin	-0.22%	1.40%	-17.27%	-2.20%	-2.41%	1.06%	-9.51%	-2.83%	7.20%	1.59%	-35.16%	-4.68%
Total Margin	-0.19%	1.43%	-17.34%	-2.16%	-2.36%	1.10%	-9.58%	-2.80%	7.27%	1.63%	-38.19%	-4.82%
Bad Debt as % Gross Revenue	-3.18%	0.09%	1.03%	0.35%	0.77%	0.15%	0.86%	0.39%	3.19%	0.41%	0.58%	0.41%
B. Liquidity												
Current Ratio	1.73	1.73	1.53	1.53	1.91	1.91	1.56	1.56	1.70	1.70	1.27	1.27
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66	70.07	70.07	48.2	48.20
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94	47.90	47.9	60.73	60.73
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69	54.38	54.38	58.9	58.90
C. Leverage and Capital Structure												
Long-term Debt to Equity	1.9083	1.9083	-23.7088	-23.7088	2.0337	2.0337	-6.2679	-6.2679	2.1620	2.1620	-2.8563	-2.8563
Long-term Debt to Capitalization	0.6562	0.6562	1.0440	1.0440	0.6704	0.6704	1.1898	1.1898	0.6837	0.6837	1.5387	1.5387
Unrestricted Cash to Debt	0.7582	0.7582	0.3218	0.3218	0.6156	0.6156	0.2694	0.2694	1.0347	1.0347	0.5303	0.5303
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31	1.55	1.55	-5.09	-5.09
Equity Financing Ratio	5.81	5.81	-76.40	-76.40	5.95	5.95	-20.33	-20.33	7.10	7.10	-9.14	-9.14
D. Additional Statistics												
Income from Operations	447,817	6,756,462	(2,301,275)	412,302	4,351	6,760,813	(1,055,933)	(648,631)	1,907,078	8,667,899	(2,987,821)	(3,631,452)
Revenue Over/(Under) Expense	(35,827)	2,588,543	(2,772,128)	(3,707,507)	(416,695)	2,171,848	(1,547,662)	(5,255,169)	1,358,560	3,530,414	(4,350,148)	(9,605,317)
Patient Cash Collected	16,953,790	173,216,936	17,588,030	165,780,926	16,191,215	189,608,151	16,367,950	182,148,876	19,856,343	209,464,494	17,283,378	199,432,254
Cash and Cash Equivalents	20,457,074	20,457,074	8,257,373	8,257,373	16,563,273	16,563,273	6,880,235	6,880,235	27,540,954	27,540,954	16,284,244	16,284,244
Net Working Capital	22,842,265	22,842,265	15,242,354	15,242,354	25,043,856	25,043,856	16,052,250	16,052,250	24,599,297	24,599,297	10,506,595	10,506,595
Unrestricted Assets	13,704,068	13,704,068	(1,045,742)	(1,045,742)	12,825,022	12,825,022	(3,936,749)	(3,936,749)	11,890,055	11,890,055	(10,064,752)	(10,064,752)
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Methodology

A. Operating Performance

Operating Margin	Income/(Loss) from Operations divided by Total Revenue
Non-Operating Margin	Net Income/(Loss) Before Changes in Unrealized Gains/(Losses) Divided by Total Revenue
Total Margin	Net Income/(Loss) divided by Total Revenue
Bad Debt as % of Gross Revenue	Bad debt divided by Gross Revenue

B. Liquidity

Current Ratio	Total Current Assets divided by Total Current Liabilities
Days Cash on Hand	Total Cash and Cash Equivalents on Balance Sheet divided by Average Daily Expenses
Days in Net Accounts Receivable	Net Accounts Receivable divided by Average Daily Revenue (rolling 3 months)
Average Payment Period	Total Current Liabilities on Balance Sheet divided by Average Daily Expenses

C. Leverage and Capital Structure

Long Term Debt to Equity	Non-Current Portion Long Term Debt divided by Net Assets

[1] In preparing the response to Question 5, a correction to the chart originally submitted in response to Question 34 was noted. This correction, which applies to Waterbury Hospital only, is reflected in the highlighted portion of the chart above.

Long Term Debt to Capitalization	Non-Current Portion Long Term Debt divided by (Non-Current Portion Long Term Debt plus Net Assets)
Unrestricted Cash to Debt	Cash and Cash Equivalents divided by Current Portion Long Term Debt plus Non-Current Portion Long Term Debt
Times Interest Earned Ratio	N/A
Debt Service Coverage Ratio	Net Income Available for Debt Service divided by Maximum Debt Service
Equity Financing Ratio	(Total Current Liabilities plus Non-Current Portion Accrued Pension plus Non-Current Portion Long Term Debt plus Other Non-Current Liabilities) divided by Net Assets

D. Additional Statistics

Income from Operations	Income/(Loss) from Operations minus Depreciation minus Interest
Revenue Over/Under Expenses	Net Income/(Loss) from Income Statement
Patient Cash Collected	Total Patient Cash Collected
Cash and Cash Equivalents	From Balance Sheet
Net Working Capital	Total Current Assets minus Total Current Liabilities
Unrestricted Assets	Net Assets on Balance Sheet
Credits Ratings (S&P, FITCH and Moody's)	N/A

Explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015

All of the "Additional Statistics" listed under Section D were negatively impacted by Waterbury Hospital's poor operating results during FY15. In FY15, the Hospital had a Deficiency of Revenues over Expenses of ($21,995,354) compared to ($6,029,225) in FY14. This deterioration is primarily attributable to a decline in Inpatient Surgical Cases from 2,126 in FY14 to 1,950 in FY15 (8.28% decline) and a decline in Outpatient Surgical Cases from 4,795 in FY14 to 4,288 in FY15 (10.57% decline). This drop in surgical cases contributed to a drop in Patient Days from 57,901 in FY14 to 55,183 in FY15 (4.69% decline), a decline in Medicare Case Mix Index from 1.51 in FY14 to 1.45 in FY15 (3.85% decline) and a decline in overall Case Mix Index from 1.31 in FY14 to 1.27 in FY15 (3.35% decline). In addition, Outpatient Cases declined from 173,720 in FY14 to 162,091 in FY15 (6.69% decline). The impact of these declines in patient volumes was a decrease in Net Patient Service Revenues of $15,699,982 from FY14 to FY15 which resulted in the decreases from FY14 to FY15 in Income from Operations, Revenue Over/(Under) Expense, Patient Cash Collected, Cash and Cash Equivalents, Net Working Capital and Unrestricted Assets noted in Section D - Additional Statistics.

6. **In reference to the Applicants' answer to Question 33 of the Response, please address the following:**

a. In response to question 33(b) the Applicants indicated that *"The non-governmental net revenue by specific payers is not usually finalized until the OHCA filing is*

***completed, so we do not have the FY 2015 final net revenue by specific payer (with allocation of charity care, bad debts, etc.)"*, hence the zero incremental amounts reported under the uninsured, self-pay and workers compensation line items.**

The amounts requested on Financial Worksheet (C) by OHCA are FY 2014 actual and projected amounts with, without and incremental associated with the proposal for FY 2015 and thereafter. Therefore, please provide a revised Financial Worksheet (C) for Waterbury Hospital that will include FY 2014 actual amounts and projected amounts for FYs 2015, and thereafter, for the uninsured, self-pay and workers compensation line items. In addition, include projected incremental amounts associated with the proposal that relates to expense items, operating income, non-operating revenue and net income. Provide the missing assumptions utilized in developing the projections and explain any projected losses from operations; and

Response:

Please see attached Exhibit Q6a-1.

b. In responding to question 33(d) the Applicants explained the expected reduction in expenses for FY 2016 but failed to explain the incremental increases in expenses as the result of this proposal for FYs 2017 and 2018. Please provide the requested information.

Response:

In responses to other questions, the Hospital indicated that they expect a lower cost structure and improved efficiencies that will generate cost savings. These expected cost savings were all built into the FY 2016 budget, and therefore moving forward into FY 2017 and FY 2018 we have only reflected general expense increases. We also noted in a previous response that FY 2017 and FY 2018 expenses increased for salary, pension, and benefit increases.

7. **In Applicants' answer to Question 19 of the Response, Applicants state that PMH has *"[p]roposed a pilot program in the state of Rhode Island to manage the health of 25,000 Medicaid patients at a cost savings to the state of Rhode Island" and that "PMH is prepared to work with the state of Connecticut on a similar proposal to manage a segment of the Medicaid population in Connecticut at cost savings to the State."* Please provide the name of the proposed Rhode Island program and a detailed description of the program and how it will achieve Medicaid savings. Include in your response the cost of implementation and projected cost savings associated with the program.**

Response:

Prospect CharterCARE Health Partners (Prospect or CharterCARE) and our sister organizations, Prospect Health Services RI, Inc. (PHSRI) and Prospect Provider Group RI, LLC (PPGRI), in April 2015 proposed to the General Assembly and Governor Gina Raimondo through the Executive Office of Health and Human Services ("EOHHS")with the elements of a three year Medicaid Coordinated Care Pilot Program which

will save the State up to $6 million dollars annually and $18 million over the three years if CharterCARE and its affiliates serve 25,000 of the State's Medicaid Recipients.

The Coordinated Care Pilot Program proposed that PHSRI would contract with one or both of the State's managed care organization (MCO) partners to serve up to 25,000 Medicaid Recipients under a fully delegated, global capitation contract at 95% of the amount for healthcare services that is currently paid by the State to the MCOs for each recipient by aide category. PHSRI would organize and manage a network of physicians, hospitals, behavioral health, social services and other providers to care for these recipients achieving better patient outcomes, higher patient satisfaction and cost reduction through effectively coordinating and integrating the care of the recipients.

The Governor included the Coordinated Care Pilot Program in her budget to the General Assembly. It was accepted by General Assembly in the FY16 budget and EOHHS released an application for interested provider groups to apply as Accountable Entities for the Coordinated Care Pilot.

The program is designed to provide a full continuum of coordinated regional care that offers integrated primary, specialty, and facility care, as well as long-term services and supports that actively engage members at the right level of care at the right time.

PHSRI is developing high impact interventions in critical areas of healthcare delivery for our members to improve their health status, increase the efficiency of the integrated delivery system, and promote the ability of our members to live fully in their communities. Our Accountable Entity ("AE") will coordinate care within a comprehensive system, closing those gaps in care that create unwarranted variation, poor clinical outcomes, avoidable utilization, and excessive cost.

We have extensive experience providing integrated and continuous care for our members in Rhode Island and several other states. Many of these relationships involve full contractual risk, fully delegated and other Value- Based Purchasing arrangements similar to those planned under the AE initiative.

The AE mission is to enhance clinical care and outcomes; engage members in their treatment and recovery, with superior satisfaction; and do so in a manner that reduces costs to Rhode Island taxpayers. We augment this commitment to the Triple Aim with a fourth commitment: to connect with providers in ways that engage and inspire them, ensuring their full commitment to the AE initiative.

This core commitment to the AE program is enhanced by our ability to integrate the mind and body, ensuring that members are offered the full continuum of behavioral healthcare services, and seamlessly integrating this care with medical and healthcare services and necessary social services.

As the program is in its early stages of implementation, actual financial cost savings have not yet accrued. However, our commitment to the State of Rhode Island at its inception was to guarantee that we would save 5% of health care costs during the first year. We anticipate that we will achieve this goal, and that we will improve the clinical quality of care as measured by a range of quality indicators developed in partnership with the State of Rhode Island.

Exhibit Q1c-1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure a staff physician (Medical Doctor [MD] 6), followed the terms of his probation, specifically, only entering a patient's room with another health care provider, i.e., MD 6 was not to visit a patient alone. This practice had the potential for patient abuse. Findings: During a review of a letter written to the Department, dated 10/15/15, and signed by the Chief Executive Officer (CEO), it read, in part: "Provider's Plan of Correction 1. Ensure that [MD 6] uses a chaperone for each patient visit: a. [MD 6] will be required to check in with Charge Nurse prior to rounding. b. Physician's Assistant (PA)/Nurse Practitioner (NP) will accompany [MD 6] during rounds. c. If PA or NP not available, Charge Nurse will round with [MD 6] or assign staff to accompany [MD 6]. d. Medical Staff Director will notify [MD 6] that he needs to take the PA/NP with him, or round with Charge Nurse or assigned staff. e. This practice will be implemented immediately. f. If [MD 6] fails to round with assigned chaperone, he will be suspended. 2. Nursing staff needs to document in the nursing record that [MD 6] was accompanied during rounds. b. Documentation of Rounding will be done by the	A 145	Immediate Actions Taken: 1. The CNO talked with Patient 21 and no adverse outcome was identified. 2. The CNO talked with Patient 23 and no adverse outcome was identified. 3. The CNO talked with Patient 24 and no adverse outcome was identified. 4. The Chief of Staff suspended MD 6 for failure to comply with the corrective action plan for a chaperone with each patient visit. 5. The CNO discussed the survey findings with RN 3, with special emphasis on strict adherence to the corrective action plan for MD 6. 6. The CEO discussed the survey findings with the Chief of Staff and MD 6, with special emphasis that the corrective action plan regarding a chaperone with each patient visit must be followed by MD 6 at all times. The CEO advised MD 6 that he is to contact Leadership if he has any difficulty with the chaperone. 7. The CEO, CNO, Chief of Staff and Information Technology (IT) staff discussed implementing an attestation in the EMR system to allow for the chaperone to attest accompanying MD 6 during patient rounds. The IT Department finalized the attestation in the EMR on 11/16/15. The chaperones were educated on the attestation and currently document the attestation in the medical record. 8. The CEO, CNO and Chief of Staff reviewed and updated the corrective action	11/9/15 11/9/15 11/9/15 11/9/15 11/9/15 11/9/15 11/16/15 11/9/15 - 11/16/15

Excerpts From CMS Statement of Deficiencies And Plan of Correction Related to Immediate Jeopardy Citations at PMH Owned Hospitals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4061 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure a staff physician (Medical Doctor [MD] 6), followed the terms of his probation, specifically, only entering a patient's room with another health care provider, i.e., MD 6 was not to visit a patient alone. This practice had the potential for patient abuse. Findings: During a review of a letter written to the Department, dated 10/15/15, and signed by the Chief Executive Officer (CEO), it read, in part: "Provider's Plan of Correction 1. Ensure that [MD 6] uses a chaperone for each patient visit: a. [MD 6] will be required to check in with Charge Nurse prior to rounding. b. Physician's Assistant (PA)/Nurse Practitioner (NP) will accompany [MD 6] during rounds. c. If PA or NP not available, Charge Nurse will round with [MD 6] or assign staff to accompany [MD 6]. d. Medical Staff Director will notify [MD 6] that he needs to take the PA/NP with him, or round with Charge Nurse or assigned staff. e. This practice will be implemented immediately. f. If [MD 6] fails to round with assigned chaperone, he will be suspended. 2. Nursing staff needs to document in the nursing record that [MD 6] was accompanied during rounds. b. Documentation of Rounding will be done by the	A 145	plan for MD 6 to clarify the chaperone instructions. A log was developed to allow for MD 6 and chaperone documentation upon arrival and departure from the hospital. The log specifies the date, a time of arrival with corresponding signatures by MD 6 and the chaperone, and the time of departure with corresponding signatures by MD 6 and the chaperone. In addition, the following instructions were put in place: a) MD 6 will sign in upon arrival to hospital and wait for a chaperone to accompany him on clinical rounds; b) the chaperone will sign the log upon MD 6's arrival and will have MD 6's patient census; c) the chaperone will accompany MD 6 on all rounds and remain with him in patient rooms; d) the chaperone will document an attestation in each patient's medical record attesting that he/she accompanied MD 6; e) the chaperone will accompany MD 6 back to the hospital lobby and both MD 6 and the chaperone signs the log indicating MD 6's departure. Nursing Leadership inserviced the chaperones on the process. 9. The CEO and MEC met with MD 6 regarding the updated corrective action plan and log. The physician's suspension was lifted 11/17/15. Compliance and Monitoring: The Chief Nursing Officer or licensed designee receives the logs on days MD 6 provides patient care at the hospital to achieve the goal of 100% compliance with	11/17/15

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MGG211 Facility ID: CA600000086

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	PA/NP/Charge Nurse, or assigned staff." During an interview with Patient 21, on 11/9/15, at 11:05 AM, he indicated MD 6 had examined him privately, with no other staff present. During an interview with Patient 23, on 11/9/15, at 11:25 AM, she indicated MD 6 had examined her privately, with no other staff present. During an interview with Patient 24, on 11/9/15, at 11:30 AM, he indicated MD 6 had examined him privately, with no other staff present. During an interview with Registered Nurse (RN) 3, on 11/9/15, at 11:40 AM, she indicated she was a Charge Nurse in the hospital. RN 3 indicated she was familiar with MD 6, and the terms of his probation. RN 3 stated in the absence of a PA/NP, nursing staff accompany MD 6 into patient rooms only "sometimes." During an interview with the CEO on 11/9/15, at 11:45 AM, while discussing the terms of MD 6's probation, she stated "[Our compliance is] not as tight as it should be on the nursing side."	A 145 A 338	MD 6 performing patient visits with a chaperone. The Director of Quality or qualified designee performs a weekly review of MD 6's medical records to monitor achieve the goal of 100% compliance with the chaperone attestation form in the EMR. The CNO or licensed designee also perform random weekly rounds on at least 3 of MD 6's patients (if available) to confirm that a chaperone was present and no issues with MD 6 are identified. Corrective action is taken as necessary, including immediate notification of the CEO and Chief of Staff for non-compliance by MD 6, and reeducation of chaperones. Data on compliance is tracked, trended, analyzed and reported every other month to MEC and Governing Board. Persons Responsible: Chief Executive Officer Chief Nursing Officer Chief of Staff	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MBG211 Facility ID: CA980000085

Excerpts From CMS Statement of Deficiencies And Plan of Correction Related to Immediate Jeopardy Citations at PMH Owned Hospitals.

Exhibit Q1c-2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health, Licensing and Certification, during a COMPLAIN VALIDATION SURVEY conducted 9/21/15 through 9/25/15. Reference Federal complaint intake CA00458231. The inspection was limited to specific Conditions of Participation: Governing Body, Patients' Rights, Quality Assessment Performance Improvement (QAPI), Nursing services, Physical Environment, Infection Control, Surgical Services and Emergency Services; and does not reflect the findings of a full inspection of the hospital. Representing the California Department of Public Health: Surveyor 22363, HFEDA Surveyor 25092, HFEN Surveyor 33720, HFEN Surveyor 32661, HFEN Surveyor 35399, HFEN Trainee Medical Consultant, 26881 Medical Consultant, 29775 The census at the Culver City campus was: 200 The census at the Hollywood campus was: 61 The census at the Van Nuys campus was: 46 Patient Records Sampled: 36 Immediate Jeopardy (IJ) 1. On 9/22/15 at 5:40 P.M. an immediate Jeopardy (IJ) was declared for the widespread pattern of potential ineffective sterility of equipment/instruments and surgical suites not	A 000	**The inspection was limited to specific Conditions or Participation: Governing Body, Patients' Rights, Quality Assessment Performance Improvement (QAPI), Nursing Services, Physical Environment, Infection Control, Surgical Services and Emergency Services; and does not reflect the findings of a full inspection of the hospital.** **Hollywood Campus** **(a, b, c)** **Immediate and Permanent Corrective Action** • On 09/22/15 at 7:15pm, Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature and humidity within regulatory limits and surgical instruments and endoscopes storage issues were identified. All surgical instruments and endoscopes were reprocessed. All OR activity ceased until compliance could be assured. • On 9/22/15 Johnson Control provided emergency service call for no cooling. • On 9/22/15 temperature and humidity were brought to within acceptable ranges. **Process Improvement:** • When a room is considered out of range, a work order is created and engineering is notified. • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the Staff has been educated on the process.	9/24/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SZ5K11 Facility ID: CA930000064

Excerpts From CMS Statement of Deficiencies And Plan of Correction Related to Immediate Jeopardy Citations at PMH Owned Hospitals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	050135	A. BUILDING _____ B. WING _____	09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	Continued From page 1 meeting the regulatory temperature and humidity limits when: a) On 9/22/15 at 3:30 p.m. during the Hollywood campus surgical services tour, main tray surgical instruments were observed stored in OR-2 where temperatures were out of regulatory limits. OR-2's thermostat meter indicated temperature of 78.8 Fahrenheit (F) and humidity of 58%. Several instrument trays were found piled on top of each other on a surgical supply storage cart. Concurrent interview was held with the administrator who confirmed that OR-2 was "too hot" and storing surgical instruments was "not good". The Administrator shared there was nowhere else to store the instruments. According to the Administrator and surgical staff interviews, instruments have always been stored in OR-2. b) Endoscopes were observed being stored in OR-3 where the thermostat meter indicated the temperature was 82.4 F and humidity was 46%. Concurrent interview was held with the interim director of infection control (IDIC) who confirmed the room temperature was out of the regulatory limits. c) The sterile processing room thermostat meter indicated a temperature of 82.5 F and humidity of 51%. Concurrent interview was held with surgical staff who confirmed the room was "hot." A review of both facilities Culver City and Hollywood Campus "Temperature and Humidity Reading" logs revealed temperature and humidity readings were out of limits on several dates. d) The index case indicated humidity ranges has been out of range at Culver City in OR # 2 for 13 days, OR # 2 for 10 days and OR # 7 for 20 days. During a tour on 9/22/15, the Department found the facility had difficulty regulating temperature and humidity in the OR's due to maintenance	A 000	Continued From page 1 • Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature. Monthly trend reporting to ACNO, IC and Quality Department occurs. No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled procedure, infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital monitoring devices will be installed in December. • Upon completion of the installation staff will be educated on requirements and individuals will be identified for notification, reporting and action. Anticipated completion date is 1/1/2016. **Date of Implementation:** • Immediate concerns corrected on 09-24-15. Installation of new monitoring devices to be completed by 01-01-2016. **Monitoring Process:** • Staff monitors and documents temperature and humidity prior to procedure. Staff monitor daily as well, on an hourly basis. Trending reports to be sent to Quality Council through EOC and Infection Control reports which will flow up to the MEC and Infection Control	

Excerpts From CMS Statement of Deficiencies And Plan of Correction Related to Immediate Jeopardy Citations at PMH Owned Hospitals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	Continued From page 2 issues with air handlers and coolers in the facility. According to administrative staff the 3 cooling units at the Culver City Campus were not adequate for the needs of the facility. Administrative staff shared the two cooling units serving the tower and surgical area needed to be replaced and the cooling unit serving the pavilion needed to be rebuilt. The HVAC systems did not have the capability of dehumidification. On 9/22/15 at 1:00 p.m., OR 3's humidity was 66%, OR 3's humidity was 66% and OR 7's humidity was 67 % to 70 %. 2. On 9/22/15 at 5:50 P.M., the CDPH survey team informed the Facility Administrative Team of an Immediate Jeopardy (IJ) identified throughout the facilities regarding questionable sterility of their surgical instruments and endoscopes since both the endoscopes and the surgical instruments were stored in surgical suites where temperatures were out of regulatory limits as well as OR humidity and temperatures ranges in both the Hollywood and Culver City campus being out of regulatory humidity and temperature ranges. 3. On 9/22/2015 at 7:10 P.M., following a meeting to discuss corrected actions taken to ensure sterility of instruments & endoscopes as well as temperature and humidity in the facility surgical suites the hospital submitted a corrective action plan, which included: 1) The immediate cessation of elective surgeries and procedures. 2) Immediately reprocessing of all surgical instruments at the Hollywood Campus. 3) Reprocessing of all the endoscopes prior to use at the Hollywood Campus. 4) All OR's at the Culver City and Hollywood campuses will be monitored for	A 000	Continued From page 2 reports which will flow up to the MEC and Governing Board for review discussion and any further action. **Position Responsible:** • Nursing Leadership, Director of Plant Operations, Director of Quality, Director of Infection Control, CEO. **Culver City Campus** **Immediate and Permanent Corrective Action (a, b, c):** • On 09/22/15 at 7:15pm, Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature and humidity within regulatory limits and surgical instruments and endoscopes storage issues were identified. All surgical instruments and endoscopes were reprocessed. All OR activity ceased until compliance could be assured. **Process Improvement:** • When a room is considered out of range, a work order is created and engineering is notified. • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the sterile supply room. • Sterile instruments were reprocessed on 9/22/15 Sterile supplies were assessed for integrity. • All sterile instruments moved to location where temperature and humidity were in range. • Nursing staff have been educated on the process. Temperatures and humidity are assessed hourly as well	9/22/2015

Excerpts From CMS Statement of Deficiencies And Plan of Correction Related to Immediate Jeopardy Citations at PMH Owned Hospitals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 000	Continued From page 3 temperature ranges every hour each 24 hours and before each procedure for each room. Temperatures will be maintained consistently on a log by nursing and engineering. OR will be taken out of service until temperatures are attained. 5) Surgical instruments will be stored in an area where temperature & humidity are within regulatory limits. 6) Assess room supplies for moisture if moisture permeation. The plan of abatement was accepted on 9/22/2015 by the survey team. 4. On 09/22/2015 at 7:15 P.M., Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature & humidity within regulatory limits and surgical instruments & endoscopes storage issues were identified. The cumulative effects of these systemic problems resulted in the hospital's in ability to provide an effective hospital wide infection control program. Resulting in the facilities inability to provide patient care in a safe and effective manner as agreed in accordance with the Condition of Participation for Infection Control Services (A 747). The seriousness of which, resulted in an Immediate Jeopardy identified by the survey team.	A 000	Continued From page 3 as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature is performed. Simultaneous reporting to Quality will occur. • No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled procedure, infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital devices will monitor temperature and humidity in the OR rooms. • On 9/24/15 a temporary cooling tower was installed in Culver City. The permanent completion of the cooling tower was accomplished on 10-28-15 for Culver City. The temporary cooling tower was removed on 11-13-15 from Culver City. **Date of Implementation:** • Immediate concerns corrected on 09-24-15. Electronic monitoring devices to be installed by 01-01- 2016. **Monitoring Process:** • Nursing monitors and documents temperature and humidity prior to procedure. Nursing staff also monitors daily on an hourly basis. Trending reports to be sent to Quality Council through EOC and Infection Control Committee reports which will flow up to the MEC and Governing Board for review discussion and any further action.	

Excerpts From CMS Statement of Deficiencies And Plan of Correction Related to Immediate Jeopardy Citations at PMH Owned Hospitals.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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			Continued From page 4 **Position Responsible:** • CNO, Nursing Leadership, Directors of Plant Operations, Director of Quality, Director of Infection Control, CEO.	

Excerpts From CMS Statement of Deficiencies And Plan of Correction Related to Immediate Jeopardy Citations at PMH Owned Hospitals.

Exhibit Q5-1

Prospect Medical Holdings, Inc. & Subsidiaries

	Month Ended 7/31/2014	FYTD 7/31/2014	Month Ended 7/31/2015	FYTD 7/31/2015	Month Ended 8/31/2014	FYTD 8/31/2014	Month Ended 8/31/2015	FYTD 8/31/2015	Month Ended 9/30/2014	FYTD 9/30/2014	Month Ended 9/30/2015	FYTD 9/30/2015	Methodology/Comments
A. Operating Performance													
Operating Margin	6.3%	7.3%	6.2%	8.0%	6.1%	7.1%	0.1%	7.3%	12.4%	7.7%	15.5%	8.0%	Operating Income / Net Revenue
Non-Operating Margin	-4.0%	-4.7%	-3.0%	-3.2%	-3.8%	-4.5%	-3.3%	-3.2%	-2.8%	-4.3%	-3.2%	-3.2%	Other (Income) Expense / Net Revenue
Total Margin	1.4%	1.4%	2.2%	3.1%	1.7%	1.4%	-1.9%	2.7%	8.4%	2.2%	1.8%	2.6%	Net Income / Net Revenue
Bad Debt as % of Gross Revenue	3.4%	4.1%	3.8%	3.4%	1.6%	3.8%	1.9%	3.3%	3.0%	3.7%	2.3%	3.2%	Bad Debt Expense / Revenue before Bad Debts (All segments)
B. Liquidity													
Current Ratio	1.0	1.0	1.1	1.1	1.0	1.0	1.1	1.1	1.0	1.0	1.1	1.1	Current Assets / Current Liabilities
Days Cash on Hand	20.7	20.7	15.0	15.0	20.1	20.1	18.4	18.4	18.6	18.6	19.8	19.8	Cash / (Trailing Twelve Months Operating Expense / 365)
Days in Net Accounts Receivables	89.0	89.0	72.5	72.5	74.1	74.1	75.6	75.6	66.4	66.4	73.4	73.4	Hospital Segment Net Accounts Receivable / (Trailing 3 Months Hospital Segment Normalized Net Patient Service Revenue / Trailing 3 Months Number of Days)
Average Payment Period	29.0	29.0	18.1	18.1	24.6	24.6	18.6	18.6	24.2	24.2	18.6	18.6	Accounts Payable / (Trailing Twelve Months Operating Expenses / 365)
C. Leverage and Capital Structure													
Long-term Debt to Equity	(37.0)	(37.0)	11.3	11.3	(42.9)	(42.9)	11.9	11.9	(349.8)	(349.8)	11.6	11.6	(Long-term debt (Current + LT portion) plus OID/OIP) / Equity
Long-term Debt to Capitalization	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	(Long-Term Debt) / (Long-term Debt + Line of Credit + Capital Leases + Equity)
Unrestricted Cash to Debt	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	Unrestricted Cash / (Long-term Debt + Line of Credit + Capital Leases)
Times Interest Earned Ratio	2.1	2.1	3.4	3.4	2.0	2.0	3.2	3.2	2.2	2.2	3.4	3.4	TTM EBITDA / TTM Interest Expense
Debt Service Coverage Ratio	12.9	12.9	42.6	42.6	13.9	13.9	42.2	42.2	18.6	18.6	46.9	46.9	TTM EBITDA / (Current portion long-term debt + Current portion of capital leases) Excludes Line of Credit
Equity Financing Ratio	(40.5)	(40.5)	12.2	12.2	(46.5)	(46.5)	12.8	12.8	(378.9)	(378.9)	12.5	12.5	(Long-term Debt + Line of Credit + Capital Leases) / Equity
D. Additional Statistics (In Thousands $ unless noted)													
Income from Operations	5,606	47,670	7,192	89,510	5,969	53,639	128	89,638	12,514	66,153	18,423	108,061	Increase from $66.2 million for FY 2014 to $108.1 million for FY 2015 due to a variety of factors. One of the primary factors was a $37.3 million increase in the net benefit of the California Hospital Fee Program (supplemental Medi-Cal reimbursement)
Net Income	1,197	8,887	2,517	34,562	1,680	10,567	(2,035)	32,528	8,448	19,015	2,111	34,639	See above regarding increase in Income from Operations from FY 2014 to FY 2015.
Patient Cash Collected - Hospital Segment only	52,482	315,730	58,220	526,009	51,706	367,436	49,913	575,923	53,637	421,073	55,047	630,969	Increase from $421 million for FY 2014 to $631 million for FY 2015 due primarily to full year of cash collections for CharterCARE during FY 2015 (acquired June 20, 2014). August 2015 low of $49.9 million due to CharterCARE Medicare billing delay resolved after several weeks. July 2015 high of $58.2 million due to increased collection efforts at Alta.
Cash and Cash Equivalents	35,715	35,715	48,625	48,625	38,638	38,638	60,247	60,247	39,072	39,072	65,606	65,606	$26.5 million increase in cash and cash equivalents from September 30, 2014 to September 30, 2015 due primarily to cash generated from operations, net of $39.5 million cash used in investing activities (primarily capital expenditures), and $8.8 million used in financing activities.
Net Working Capital	4,938	4,938	38,856	38,856	6,927	6,927	36,940	36,940	8,618	8,618	25,710	25,710	Increase in net working capital due from September 30, 2014 to September 30, 2015 due to multiple factors including: (1) $26.5 million increase in unrestricted cash (see comment above). (2) $20.1 million increase in net QAF receivable/liability due to timing of GAAP recognition versus cash receipts (3) $14.2 million increase in medical claims IBNR due to increased membership in our Hospital and Medical Group segments (4) Various changes in other components of net working capital
Unrestricted Assets	694,684	694,684	829,153	829,153	699,754	699,754	838,760	838,760	761,317	761,317	782,851	782,851	Total assets increased $21.5 million from $761.3 million at September 30, 2014 to $782.9 million at September 30, 2015. See comments above regarding net working capital. In addition, net fixed assets increased $10.9 million as a result of capital expenditures.
Credit Ratings									B2 /B-	B2 / B-	B1 / B	B1 / B	

Exhibit Q6a-1

FINANCIAL WORKSHEET DESCRIPTIONS

Financial Worsheet:

C– Sale of Non-Profit Hospital to For-Profit Entity

Cells Legend:

	Indicates input cell
	Indicates calculated cell

Columns 1,2,5,8 & 11: **Add Non-Profit data (without CON)**

Columns 3,4,6,7,9,10,12 & 13: **Add For-Profit data (with CON & incremental to CON)**

Sale of Non-Profit Hosptal to For-Profit Entity

Name Entity:

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY Actual Results	(2) FY Projected W/out CON	(3) FY Projected Incremental	(4) FY Projected With CON	(5) FY Projected W/out CON	(6) FY Projected Incremental	(7) FY Projected With CON	(8) FY Projected W/out CON	(9) FY Projected Incremental	(10) FY Projected With CON	(11) FY Projected W/out CON	(12) FY Projected Incremental	(13) FY Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue				$0			$0			$0			$0
2	Less: Allowances				$0			$0			$0			$0
3	Less: Charity Care				$0			$0			$0			$0
4	Less: Other Deductions				$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare				$0			$0			$0			$0
6	Medicaid				$0			$0			$0			$0
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers				$0			$0			$0			$0
10	Uninsured				$0			$0			$0			$0
11	Self Pay				$0			$0			$0			$0
12	Workers Compensation				$0			$0			$0			$0
13	Other				$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts				**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue				**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions				**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages				$0			$0			$0			$0
2	Fringe Benefits				$0			$0			$0			$0
3	Physicians Fees				$0			$0			$0			$0
4	Supplies and Drugs				$0			$0			$0			$0
5	Depreciation and Amortization				$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]				$0			$0			$0			$0
7	Interest Expense				$0			$0			$0			$0
8	Malpractice Insurance Cost				$0			$0			$0			$0
9	Lease Expense				$0			$0			$0			$0
10	Other Operating Expenses				$0			$0			$0			$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Provision for Income Taxes[c]				**$0**			**$0**			**$0**			**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME / (LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING INCOME / REVENUE				**$0**			**$0**			**$0**			**$0**

Sale of Non-Profit Hosptal to For-Profit Entity

Name Entity:

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C.	Retained Earnings/ Net Assets, beginning of year				$0			$0			$0			$0
	Retained Earnings / Net Assets, end of year				$0			$0			$0			$0
	Principal Payments				$0			$0			$0			$0
D.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
E.	FTEs				0			0			0			0
F.	VOLUME STATISTICS[d]													
1	Inpatient Discharges				0			0			0			0
2	Outpatient Visits				0			0			0			0
	TOTAL VOLUME	0	0	0	0	0	0	0	0	0	0	0	0	0

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Financial Worksheet Assumptions

Waterbury Hospital

FY 2015
October through August results annualized

FY 2016
Revenue and Volume-annualized 5 months of actual results (February through June). Inlcuded additional revenue for anticipated increase in outpatient volume and known revenue increases from Medicare and Commercial payers.

Expenses-annualized 7 months of actual results (October through April). Included any projected changes as identified during the budget process

Both revenue and expenses reflect expected changes due to the impact of the recent State Supplemental Pool payment cuts.

FY 2017 and 2018
FTE's and volume was kept the same as the budget. No increases.
Revenue increases reflected for known Commercial contract changes.
Expenses increased for overall salary, pension, and medical benefit increases.

Alliance Medical Group

FY 2015
Base was an average of the previous 11 months for individual government and non-government revenue. For all other items, used the 11 month YTD plus the month of August again.

FY 2016
Based on potential visit volumes for the upcoming year.

FY 2017 and 2018
Based on the expected increase of 1% to 2% per year due to the primary care recruitment which will include opening offices in new markets.

For the new fiscal years, there has been extensive evaluation of the expenses associated with the hospital and all affiliates. The Hospital engaged the Camden Group to look at opportunities to remove expenses from the organization and we have begun or about to begin implementing many of these based on the data analyzed. Our goal moving forward and starting in FY 2016 is to increase our revenue capability but also make significant changes that will allow us to decrease our expenses where appropriate.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Greater Waterbury Health Network

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 14**	**FY 15**	**FY 15**	**FY 15**	**FY 16**	**FY 16**	**FY 16**	**FY 17**	**FY 17**	**FY 17**	**FY 18**	**FY 18**	**FY 18**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$990,678,984	$1,000,485,065		$1,000,485,065	$1,006,038,550		$1,006,038,550	$1,019,877,764		$1,019,877,764	$1,029,226,891		$1,029,226,891
2	Less: Allowances	$723,461,546	$743,265,348		$743,265,348	$745,519,202		$745,519,202	$756,087,352		$756,087,352	$763,176,134		$763,176,134
3	Less: Charity Care	$5,831,559	$5,144,570		$5,144,570	$5,228,272		$5,228,272	$5,228,272		$5,228,272	$5,228,272		$5,228,272
4	Less: Other Deductions	$8,317,191	$9,054,147		$9,054,147	$12,436,400		$12,436,400	$12,436,400		$12,436,400	$12,436,400		$12,436,400
	Net Patient Service Revenue	**$253,068,688**	**$243,021,000**	**$0**	**$243,021,000**	**$242,854,677**	**$0**	**$242,854,677**	**$246,125,740**	**$0**	**$246,125,740**	**$248,386,086**	**$0**	**$248,386,086**
5	Medicare	$103,628,153	$94,049,325		$94,049,325	$93,959,132		$93,959,132	$94,250,524		$94,250,524	$94,408,975		$94,408,975
6	Medicaid	$39,293,712	$49,412,291		$49,412,291	$53,348,771		$53,348,771	$53,529,715		$53,529,715	$53,615,899		$53,615,899
7	CHAMPUS & TriCare	$384,633	$361,306		$361,306	$371,375		$371,375	$372,204		$372,204	$372,816		$372,816
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$143,306,497**	**$143,822,921**	**$0**	**$143,822,921**	**$147,679,278**	**$0**	**$147,679,278**	**$148,152,443**	**$0**	**$148,152,443**	**$148,397,690**	**$0**	**$148,397,690**
9	Commercial Insurers	$90,287,422	$87,265,292		$87,265,292	$91,679,052		$91,679,052	$94,158,116		$94,158,116	$95,949,432		$95,949,432
10	Uninsured	$130,613	$128,767		$128,767	$182,978		$182,978	$183,574		$183,574	$183,574		$183,574
11	Self Pay	$3,734,316	$5,041,516		$5,041,516	$2,957,704		$2,957,704	$3,028,936		$3,028,936	$3,077,104		$3,077,104
12	Workers Compensation	$16,167,440	$10,309,021		$10,309,021	$8,708,474		$8,708,474	$8,953,588		$8,953,588	$9,126,126		$9,126,126
13	Other	($557,601)	($3,546,517)		($3,546,517)	($8,352,810)		($8,352,810)	($8,350,917)		($8,350,917)	($8,347,840)		($8,347,840)
	Total Non-Government	**$109,762,190**	**$99,198,079**	**$0**	**$99,198,079**	**$95,175,399**	**$0**	**$95,175,399**	**$97,973,297**	**$0**	**$97,973,297**	**$99,988,396**	**$0**	**$99,988,396**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$253,068,688**	**$243,021,000**	**$0**	**$243,021,000**	**$242,854,677**	**$0**	**$242,854,677**	**$246,125,740**	**$0**	**$246,125,740**	**$248,386,086**	**$0**	**$248,386,086**
14	Less: Provision for Bad Debts	$4,480,248	$4,347,405		**$4,347,405**	$3,468,763		**$3,468,763**	$3,516,689		**$3,516,689**	$3,543,303		**$3,543,303**
	Net Patient Service Revenue less provision for bad debts	**$248,588,440**	**$238,673,596**	**$0**	**$238,673,596**	**$239,385,914**	**$0**	**$239,385,914**	**$242,609,051**	**$0**	**$242,609,051**	**$244,842,783**	**$0**	**$244,842,783**
15	Other Operating Revenue	$12,014,569	$11,694,375		**$11,694,375**	$14,643,067		**$14,643,067**	$14,825,462		**$14,825,462**	$14,878,373		**$14,878,373**
17	Net Assets Released from Restrictions	$5,542,491	$5,080,455		**$5,080,455**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**
	TOTAL OPERATING REVENUE	**$266,145,499**	**$255,448,426**	**$0**	**$255,448,426**	**$259,280,613**	**$0**	**$259,280,613**	**$262,686,146**	**$0**	**$262,686,146**	**$264,972,788**	**$0**	**$264,972,788**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$119,127,829	$120,430,846		$120,430,846	$115,590,029		$115,590,029	$117,692,915		$117,692,915	$119,507,521		$119,507,521
2	Fringe Benefits	$29,567,048	$35,027,007		$35,027,007	$33,907,301		$33,907,301	$34,900,546		$34,900,546	$36,161,608		$36,161,608
3	Physicians Fees	$18,806,920	$14,968,038		$14,968,038	$12,697,776		$12,697,776	$12,680,260		$12,680,260	$12,682,807		$12,682,807
4	Supplies and Drugs	$31,348,505	$29,295,392		$29,295,392	$23,712,061		$23,712,061	$23,917,529		$23,917,529	$24,142,219		$24,142,219
5	Depreciation and Amortization	$7,913,151	$7,063,006		$7,063,006	$6,849,701		$6,849,701	$6,838,400		$6,838,400	$6,830,365		$6,830,365
6	Provision for Bad Debts-Other[b]	$15,000	$15,000		$15,000	$15,000		$15,000	$15,000		$15,000	$15,000		$15,000
7	Interest Expense	$1,213,488	$1,172,296		$1,172,296	$1,278,230		$1,278,230	$1,246,208		$1,246,208	$1,213,800		$1,213,800
8	Malpractice Insurance Cost	$8,249,305	$8,268,731		$8,268,731	$6,901,688		$6,901,688	$6,928,910		$6,928,910	$6,931,831		$6,931,831
9	Lease Expense	$3,787,527	$4,045,091		$4,045,091	$3,612,010		$3,612,010	$3,623,435		$3,623,435	$3,635,055		$3,635,055
10	Other Operating Expenses	$54,014,082	$53,166,763		$53,166,763	$57,710,072		$57,710,072	$57,496,322		$57,496,322	$57,779,059		$57,779,059
	TOTAL OPERATING EXPENSES	**$274,042,856**	**$273,452,169**	**$0**	**$273,452,169**	**$262,273,868**	**$0**	**$262,273,868**	**$265,339,526**	**$0**	**$265,339,526**	**$268,899,265**	**$0**	**$268,899,265**
	Provision for Income Taxes[c]	$150,779	$141,985		**$141,985**	$136,181		**$136,181**	$136,181		**$136,181**	$136,181		**$136,181**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$1,229,283**	**($9,768,441)**	**$0**	**($9,768,441)**	**$5,134,676**	**$0**	**$5,134,676**	**$5,431,229**	**$0**	**$5,431,229**	**$4,117,688**	**$0**	**$4,117,688**
	INCOME / (LOSS) FROM OPERATIONS	**($8,048,136)**	**($18,145,727)**	**$0**	**($18,145,727)**	**($3,129,436)**	**$0**	**($3,129,436)**	**($2,789,561)**	**$0**	**($2,789,561)**	**($4,062,658)**	**$0**	**($4,062,658)**
	NON-OPERATING INCOME / REVENUE	$3,370,120	$2,425,698		**$2,425,698**	$3,442,234		**$3,442,234**	$3,467,981		**$3,467,981**	$3,494,886		**$3,494,886**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**($4,678,016)**	**($15,720,030)**	**$0**	**($15,720,030)**	**$312,798**	**$0**	**$312,798**	**$678,420**	**$0**	**$678,420**	**($567,772)**	**$0**	**($567,772)**
C.	**Retained Earnings / Net Assets, beginning of year**	**$51,708,831**	**$45,505,137**		**$45,505,137**	**$29,061,392**		**$29,061,392**	**$29,374,190**		**$29,374,190**	**$30,052,610**		**$30,052,610**
	Retained Earnings / Net Assets, end of year	**$45,505,137**	**$29,061,392**		**$29,061,392**	**$29,374,190**		**$29,374,190**	**$30,052,610**		**$30,052,610**	**$29,484,839**		**$29,484,839**
	Principal Payments	$298,904	$44,701		**$44,701**	$29,709		**$29,709**	$14,001		**$14,001**	$6,571		**$6,571**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**-3.0%**	**-7.0%**	**0.0%**	**-7.0%**	**-1.2%**	**0.0%**	**-1.2%**	**-1.0%**	**0.0%**	**-1.0%**	**-1.5%**	**0.0%**	**-1.5%**
2	Hospital Non Operating Margin	**1.3%**	**0.9%**	**0.0%**	**0.9%**	**1.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**1.3%**
3	Hospital Total Margin	**-1.7%**	**-6.1%**	**0.0%**	**-6.1%**	**0.1%**	**0.0%**	**0.1%**	**0.3%**	**0.0%**	**0.3%**	**-0.2%**	**0.0%**	**-0.2%**
E.	**FTEs**	**1,530**	**1,417**		**1,417**	**1,484**		**1,484**	**1,486**		**1,486**	**1,489**		**1,489**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Greater Waterbury Health Network
Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
F.	VOLUME STATISTICS[d]													
1	Inpatient Discharges	11,693	11,699		**11,699**	11,344		**11,344**	11,344		**11,344**	11,344		**11,344**
2	Outpatient Visits	199,362	188,806		**188,806**	192,582		**192,582**	192,582		**192,582**	192,582		**192,582**
	TOTAL VOLUME	**211,055**	**200,505**	**0**	**200,505**	**203,926**	**0**	**203,926**	**203,926**	**0**	**203,926**	**203,926**	**0**	**203,926**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: GW Network

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 14 Actual**	**FY 15 Projected**	**FY 15 Projected**	**FY 15 Projected**	**FY 16 Projected**	**FY 16 Projected**	**FY 16 Projected**	**FY 17 Projected**	**FY 17 Projected**	**FY 17 Projected**	**FY 18 Projected**	**FY 18 Projected**	**FY 18 Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0		$0	$0		$0	$0		$0	$0		$0
2	Less: Allowances	$0	$0		$0	$0		$0	$0		$0	$0		$0
3	Less: Charity Care	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0		$0	$0		$0	$0		$0	$0		$0
6	Medicaid	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	CHAMPUS & TriCare	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$0	$0		$0	$0		$0	$0		$0	$0		$0
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$0	$0		$0	$0		$0	$0		$0	$0		$0
13	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
17	Net Assets Released from Restrictions	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0		$0	$0		$0	$0		$0	$0		$0
2	Fringe Benefits	$0	$0		$0	$0		$0	$0		$0	$0		$0
3	Physicians Fees	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Supplies and Drugs	$0	$0		$0	$0		$0	$0		$0	$0		$0
5	Depreciation and Amortization	$0	$0		$0	$0		$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$0	$0		$0	$0		$0	$0		$0	$0		$0
9	Lease Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$68,181	$95,413		$95,413	$84,048		$84,048	$84,048		$84,048	$84,048		$84,048
	TOTAL OPERATING EXPENSES	**$68,181**	**$95,413**	**$0**	**$95,413**	**$84,048**	**$0**	**$84,048**	**$84,048**	**$0**	**$84,048**	**$84,048**	**$0**	**$84,048**
	Provision for Income Taxes[c]	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**($68,181)**	**($95,413)**	**$0**	**($95,413)**	**($84,048)**	**$0**	**($84,048)**	**($84,048)**	**$0**	**($84,048)**	**($84,048)**	**$0**	**($84,048)**
	INCOME / (LOSS) FROM OPERATIONS	**($68,181)**	**($95,413)**	**$0**	**($95,413)**	**($84,048)**	**$0**	**($84,048)**	**($84,048)**	**$0**	**($84,048)**	**($84,048)**	**$0**	**($84,048)**
	NON-OPERATING INCOME / REVENUE	($18,434)	($235,193)		**($235,193)**	$643,190		**$643,190**	$668,351		**$668,351**	$694,645		**$694,645**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**($86,615)**	**($330,607)**	**$0**	**($330,607)**	**$559,142**	**$0**	**$559,142**	**$584,303**	**$0**	**$584,303**	**$610,597**	**$0**	**$610,597**
C	**Retained Earnings/ Net Assets, beginning of year**	**$17,178,778**	**$17,092,163**		**$17,092,163**	**$16,761,556**		**$16,761,556**	**$17,320,698**		**$17,320,698**	**$17,905,002**		**$17,905,002**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: GW Network

Financial Worksheet (C): Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**Retained Earnings / Net Assets, end of year**	$17,092,163	$16,761,556		$16,761,556	$17,320,698		$17,320,698	$17,905,002		$17,905,002	$18,515,599		$18,515,599
	Principal Payments	$0	$0		$0	$0		$0	$0		$0	$0		$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	369.9%	40.6%	0.0%	40.6%	-13.1%	0.0%	-13.1%	-12.6%	0.0%	-12.6%	-12.1%	0.0%	-12.1%
2	Hospital Non Operating Margin	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%
3	Hospital Total Margin	469.9%	140.6%	0.0%	140.6%	86.9%	0.0%	86.9%	87.4%	0.0%	87.4%	87.9%	0.0%	87.9%
E.	**FTEs**	$0	$0		0	$0		0	$0		0	$0		0
F.	**VOLUME STATISTICS**[d]													
1	Inpatient Discharges	$0	$0		0	$0		0	$0		0	$0		0
2	Outpatient Visits	$0	$0		0	$0		0	$0		0	$0		0
	TOTAL VOLUME	0	0	0	0	0	0	0	0	0	0	0	0	0

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Assumed no increases in volume. Only increase was managed care

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Waterbury Hospital

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Financial Worksheet (C):

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 14 Actual Results**	**FY 15 Projected W/out CON**	**FY 15 Projected Incremental**	**FY 15 Projected With CON**	**FY 16 Projected W/out CON**	**FY 16 Projected Incremental**	**FY 16 Projected With CON**	**FY 17 Projected W/out CON**	**FY 17 Projected Incremental**	**FY 17 Projected With CON**	**FY 18 Projected W/out CON**	**FY 18 Projected Incremental**	**FY 18 Projected With CON**
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$905,475,426	915,214,960		$915,214,960	$921,598,035		$921,598,035	$934,060,739		$934,060,739	$942,681,350		$942,681,350
2	Less: Allowances	$679,028,148	698,950,496		$698,950,496	$702,469,850		$702,469,850	$712,240,611		$712,240,611	$718,999,172		$718,999,172
3	Less: Charity Care	$5,839,904	5,156,745		$5,156,745	$5,243,272		$5,243,272	$5,243,272		$5,243,272	$5,243,272		$5,243,272
4	Less: Other Deductions	$8,287,736	9,039,311		$9,039,311	$12,421,400		$12,421,400	$12,421,400		$12,421,400	$12,421,400		$12,421,400
	Net Patient Service Revenue	**$212,319,638**	**$202,068,409**	**$0**	**$202,068,409**	**$201,463,513**	**$0**	**$201,463,513**	**$204,155,456**	**$0**	**$204,155,456**	**$206,017,506**	**$0**	**$206,017,506**
5	Medicare	$88,141,859	$77,846,951		$77,846,951	$77,683,507		$77,683,507	$77,683,507		$77,683,507	$77,683,507		$77,683,507
6	Medicaid	$31,612,939	$41,641,364		$41,641,364	$45,383,059		$45,383,059	$45,383,059		$45,383,059	$45,383,059		$45,383,059
7	CHAMPUS & TriCare	$278,693	$257,504		$257,504	$264,002		$264,002	$264,002		$264,002	$264,002		$264,002
8	Other				$0			$0			$0			$0
	Total Government	**$120,033,491**	**$119,745,818**	**$0**	**$119,745,818**	**$123,330,568**	**$0**	**$123,330,568**	**$123,330,568**	**$0**	**$123,330,568**	**$123,330,568**	**$0**	**$123,330,568**
9	Commercial Insurers	$76,415,094	$73,778,665		$73,778,665	$77,915,859		$77,915,859	$80,308,310		$80,308,310	$81,963,198		$81,963,198
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$3,063,302	$4,256,654		$4,256,654	$2,156,999		$2,156,999	$2,223,231		$2,223,231	$2,269,044		$2,269,044
12	Workers Compensation	$14,664,997	$8,890,001		$8,890,001	$7,596,670		$7,596,670	$7,829,930		$7,829,930	$7,991,279		$7,991,279
13	Other	($1,857,246)	($4,602,729)		($4,602,729)	($9,536,583)		($9,536,583)	($9,536,583)		($9,536,583)	($9,536,583)		($9,536,583)
	Total Non-Government	**$92,286,147**	**$82,322,591**	**$0**	**$82,322,591**	**$78,132,945**	**$0**	**$78,132,945**	**$80,824,888**	**$0**	**$80,824,888**	**$82,686,938**	**$0**	**$82,686,938**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$212,319,638**	**$202,068,409**	**$0**	**$202,068,409**	**$201,463,513**	**$0**	**$201,463,513**	**$204,155,456**	**$0**	**$204,155,456**	**$206,017,506**	**$0**	**$206,017,506**
14	Less: Provision for Bad Debts	$3,692,986	3,602,119		**$3,602,119**	$2,696,864		**$2,696,864**	$2,732,899		**$2,732,899**	$2,757,825		**$2,757,825**
	Net Patient Service Revenue less provision for bad debts	**$208,626,652**	**$198,466,291**	**$0**	**$198,466,291**	**$198,766,649**	**$0**	**$198,766,649**	**$201,422,556**	**$0**	**$201,422,556**	**$203,259,680**	**$0**	**$203,259,680**
15	Other Operating Revenue	$2,671,751	1,164,098		**$1,164,098**	$2,364,706		**$2,364,706**	$2,364,706		**$2,364,706**	$2,364,706		**$2,364,706**
17	Net Assets Released from Restrictions	$5,542,491	5,080,455		**$5,080,455**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**
	TOTAL OPERATING REVENUE	**$216,840,894**	**$204,710,844**	**$0**	**$204,710,844**	**$206,382,987**	**$0**	**$206,382,987**	**$209,038,894**	**$0**	**$209,038,894**	**$210,876,018**	**$0**	**$210,876,018**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$83,908,937	$82,721,899		$82,721,899	$77,111,340		$77,111,340	$78,653,567		$78,653,567	$80,226,638		$80,226,638
2	Fringe Benefits	$23,614,272	$28,882,017		$28,882,017	$27,269,762		$27,269,762	$28,417,803		$28,417,803	$29,645,411		$29,645,411
3	Physicians Fees	$17,306,125	$11,926,799		$11,926,799	$11,229,459		$11,229,459	$11,229,459		$11,229,459	$11,229,459		$11,229,459
4	Supplies and Drugs	$29,780,875	$27,722,303		$27,722,303	$21,913,022		$21,913,022	$22,125,763		$22,125,763	$22,344,887		$22,344,887
5	Depreciation and Amortization	$7,077,295	$6,340,513		$6,340,513	$6,200,315		$6,200,315	$6,200,315		$6,200,315	$6,200,315		$6,200,315
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0			$0			$0
7	Interest Expense	$1,196,363	$1,169,431		$1,169,431	$1,277,911		$1,277,911	$1,246,139		$1,246,139	$1,213,731		$1,213,731
8	Malpractice Insurance Cost	$6,226,587	$6,543,668		$6,543,668	$5,392,785		$5,392,785	$5,392,785		$5,392,785	$5,392,785		$5,392,785
9	Lease Expense	$2,599,451	$2,852,443		$2,852,443	$2,401,696		$2,401,696	$2,401,696		$2,401,696	$2,401,696		$2,401,696
10	Other Operating Expenses	$56,039,173	$57,223,873		$57,223,873	$58,849,639		$58,849,639	$58,393,012		$58,393,012	$58,506,655		$58,506,655
	TOTAL OPERATING EXPENSES	**$227,749,078**	**$225,382,944**	**$0**	**$225,382,944**	**$211,645,929**	**$0**	**$211,645,929**	**$214,060,539**	**$0**	**$214,060,539**	**$217,161,577**	**$0**	**$217,161,577**
	Provision for Income Taxes[c]				**$0**			**$0**			**$0**			**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**($2,634,526)**	**($13,162,156)**	**$0**	**($13,162,156)**	**$2,215,284**	**$0**	**$2,215,284**	**$2,424,809**	**$0**	**$2,424,809**	**$1,128,487**	**$0**	**$1,128,487**
	INCOME / (LOSS) FROM OPERATIONS	**($10,908,184)**	**($20,672,100)**	**$0**	**($20,672,100)**	**($5,262,942)**	**$0**	**($5,262,942)**	**($5,021,645)**	**$0**	**($5,021,645)**	**($6,285,559)**	**$0**	**($6,285,559)**
	NON-OPERATING INCOME / REVENUE	$3,136,173	$2,503,676		**$2,503,676**	$2,658,589		**$2,658,589**	$2,658,589		**$2,658,589**	$2,658,589		**$2,658,589**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**($7,772,011)**	**($18,168,424)**	**$0**	**($18,168,424)**	**($2,604,353)**	**$0**	**($2,604,353)**	**($2,363,056)**	**$0**	**($2,363,056)**	**($3,626,970)**	**$0**	**($3,626,970)**
C.	**Retained Earnings / Net Assets, beginning of year**	**$18,667,399**	**$11,890,055**		**$11,890,055**	**($4,698,443)**		**($4,698,443)**	**($7,302,796)**		**($7,302,796)**	**($9,665,852)**		**($9,665,852)**
	Retained Earnings / Net Assets, end of year	**$11,890,055**	**($4,698,443)**		**($4,698,443)**	**($7,302,796)**		**($7,302,796)**	**($9,665,852)**		**($9,665,852)**	**($13,292,821)**		**($13,292,821)**
	Principal Payments				**$0**			**$0**			**$0**			**$0**

Assumed no increases in volume. Only increase was managed care

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Waterbury Hospital

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	D. PROFITABILITY SUMMARY													
1	Hospital Operating Margin	**-5.0%**	**-10.0%**	**0.0%**	**-10.0%**	**-2.5%**	**0.0%**	**-2.5%**	**-2.4%**	**0.0%**	**-2.4%**	**-2.9%**	**0.0%**	**-2.9%**
2	Hospital Non Operating Margin	**1.4%**	**1.2%**	**0.0%**	**1.2%**	**1.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**1.3%**	**1.2%**	**0.0%**	**1.2%**
3	Hospital Total Margin	**-3.5%**	**-8.8%**	**0.0%**	**-8.8%**	**-1.2%**	**0.0%**	**-1.2%**	**-1.1%**	**0.0%**	**-1.1%**	**-1.7%**	**0.0%**	**-1.7%**
	E. FTEs	**1,152**	1,028		**1,028**	1,091		**1,091**	1,091		**1,091**	1,091		**1,091**
	F. VOLUME STATISTICS[d]													
1	Inpatient Discharges	11,693	11,699		**11,699**	11,344		**11,344**	11,344		**11,344**	11,344		**11,344**
2	Outpatient Visits	199,362	188,806		**188,806**	192,582		**192,582**	192,582		**192,582**	192,582		**192,582**
	TOTAL VOLUME	**211,055**	**200,505**	**0**	**200,505**	**203,926**	**0**	**203,926**	**203,926**	**0**	**203,926**	**203,926**	**0**	**203,926**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Alliance Medical Group

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14 Actual	FY 15 Projected	FY 15 Projected	FY 15 Projected	FY 16 Projected	FY 16 Projected	FY 16 Projected	FY 17 Projected	FY 17 Projected	FY 17 Projected	FY 18 Projected	FY 18 Projected	FY 18 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$37,156,345	$36,005,955		$36,005,955	$35,887,319		$35,887,319	$36,605,066		$36,605,066	$36,971,116		$36,971,116
2	Less: Allowances	$20,282,805	$19,353,356		$19,353,356	$19,027,905		$19,027,905	$19,408,463		$19,408,463	$19,602,547		$19,602,547
3	Less: Charity Care	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$16,873,540**	**$16,652,599**	**$0**	**$16,652,599**	**$16,859,415**	**$0**	**$16,859,415**	**$17,196,603**	**$0**	**$17,196,603**	**$17,368,569**	**$0**	**$17,368,569**
5	Medicare	$5,901,290	$6,138,897		$6,138,897	$6,211,423		$6,211,423	$6,335,651		$6,335,651	$6,399,007		$6,399,007
6	Medicaid	$3,068,780	$3,045,122		$3,045,122	$3,143,744		$3,143,744	$3,206,619		$3,206,619	$3,238,685		$3,238,685
7	CHAMPUS & TriCare	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$8,970,070**	**$9,184,019**	**$0**	**$9,184,019**	**$9,355,166**	**$0**	**$9,355,166**	**$9,542,270**	**$0**	**$9,542,270**	**$9,637,692**	**$0**	**$9,637,692**
9	Commercial Insurers	$7,634,611	$7,290,724		$7,290,724	$7,328,573		$7,328,573	$7,475,145		$7,475,145	$7,549,896		$7,549,896
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$129,981	$128,167		$128,167	$126,614		$126,614	$129,146		$129,146	$130,438		$130,438
12	Workers Compensation	$106,554	$46,164		$46,164	$45,520		$45,520	$46,431		$46,431	$46,895		$46,895
13	Other	$32,324	$3,526		$3,526	$3,540		$3,540	$3,611		$3,611	$3,647		$3,647
	Total Non-Government	**$7,903,470**	**$7,468,580**	**$0**	**$7,468,580**	**$7,504,248**	**$0**	**$7,504,248**	**$7,654,333**	**$0**	**$7,654,333**	**$7,730,877**	**$0**	**$7,730,877**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$16,873,540**	**$16,652,599**	**$0**	**$16,652,599**	**$16,859,415**	**$0**	**$16,859,415**	**$17,196,603**	**$0**	**$17,196,603**	**$17,368,569**	**$0**	**$17,368,569**
14	Less: Provision for Bad Debts	$518,641	$471,378		**$471,378**	$473,971		**$473,971**	$473,971		**$473,971**	$473,971		**$473,971**
	Net Patient Service Revenue less provision for bad debts	**$16,354,898**	**$16,181,221**	**$0**	**$16,181,221**	**$16,385,444**	**$0**	**$16,385,444**	**$16,722,632**	**$0**	**$16,722,632**	**$16,894,598**	**$0**	**$16,894,598**
15	Other Operating Revenue	$4,481,259	$5,461,132		**$5,461,132**	$7,363,945		**$7,363,945**	$7,363,945		**$7,363,945**	$7,363,945		**$7,363,945**
17	Net Assets Released from Restrictions	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$20,836,157**	**$21,642,353**	**$0**	**$21,642,353**	**$23,749,389**	**$0**	**$23,749,389**	**$24,086,577**	**$0**	**$24,086,577**	**$24,258,543**	**$0**	**$24,258,543**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$16,530,304	$17,932,673		$17,932,673	$18,926,070		$18,926,070	$18,926,070		$18,926,070	$18,926,070		$18,926,070
2	Fringe Benefits	$2,917,173	$2,820,283		$2,820,283	$2,857,626		$2,857,626	$2,857,626		$2,857,626	$2,857,626		$2,857,626
3	Physicians Fees	$731,660	$2,370,482		$2,370,482	$748,943		$748,943	$748,943		$748,943	$748,943		$748,943
4	Supplies and Drugs	$843,095	$838,257		$838,257	$1,037,432		$1,037,432	$1,037,432		$1,037,432	$1,037,432		$1,037,432
5	Depreciation and Amortization	$371,630	$312,280		$312,280	$257,869		$257,869	$257,869		$257,869	$257,869		$257,869
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$17,085	$2,864		$2,864	$19		$19	$19		$19	$19		$19
8	Malpractice Insurance Cost	$1,616,892	$1,300,883		$1,300,883	$1,107,023		$1,107,023	$1,107,023		$1,107,023	$1,107,023		$1,107,023
9	Lease Expense	$31,776	$27,445		$27,445	$28,025		$28,025	$28,025		$28,025	$28,025		$28,025
10	Other Operating Expenses	($2,260,006)	($3,993,483)		($3,993,483)	($1,240,509)		($1,240,509)	($903,321)		($903,321)	($731,355)		($731,355)
	TOTAL OPERATING EXPENSES	**$20,799,609**	**$21,611,684**	**$0**	**$21,611,684**	**$23,722,498**	**$0**	**$23,722,498**	**$24,059,686**	**$0**	**$24,059,686**	**$24,231,652**	**$0**	**$24,231,652**
	Provision for Income Taxes[c]	$150,779	$141,985		**$141,985**	$136,181		**$136,181**	$136,181		**$136,181**	$136,181		**$136,181**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$425,263**	**$345,812**	**$0**	**$345,812**	**$284,779**	**$0**	**$284,779**	**$284,779**	**$0**	**$284,779**	**$284,779**	**$0**	**$284,779**
	INCOME / (LOSS) FROM OPERATIONS	**($114,231)**	**($111,316)**	**$0**	**($111,316)**	**($109,290)**	**$0**	**($109,290)**	**($109,290)**	**$0**	**($109,290)**	**($109,290)**	**$0**	**($109,290)**
	NON-OPERATING INCOME / REVENUE	$114,231	$111,316		**$111,316**	$109,290		**$109,290**	$109,290		**$109,290**	$109,290		**$109,290**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**($0)**	**($0)**	**$0**	**($0)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
C	**Retained Earnings / Net Assets, beginning of year**	**$4,342,656**	**$4,403,019**		**$4,403,019**	**$4,403,019**		**$4,403,019**	**$4,403,019**		**$4,403,019**	**$4,403,019**		**$4,403,019**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Alliance Medical Group

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**Retained Earnings / Net Assets, end of year**	$4,403,019	$4,403,019		$4,403,019	$4,403,019		$4,403,019	$4,403,019		$4,403,019	$4,403,020		$4,403,020
	Principal Payments	$296,512	$44,701		$44,701	$29,709		$29,709	$14,001		$14,001	$6,571		$6,571
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	-0.5%	-0.5%	0.0%	-0.5%	-0.5%	0.0%	-0.5%	-0.5%	0.0%	-0.5%	-0.4%	0.0%	-0.4%
2	Hospital Non Operating Margin	0.5%	0.5%	0.0%	0.5%	0.5%	0.0%	0.5%	0.5%	0.0%	0.5%	0.4%	0.0%	0.4%
3	Hospital Total Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
E.	**FTEs**	173	175		175	175		175	175		175	175		175
F.	**VOLUME STATISTICS**[d]													
1	Inpatient Discharges				0			0			0			0
2	Outpatient Visits	153,852	117,793		117,793	126,213		126,213	128,737		128,737	131,262		131,262
	TOTAL VOLUME	153,852	117,793	0	117,793	126,213	0	126,213	128,737	0	128,737	131,262	0	131,262

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Cardiology Associates of GW

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14 Actual	FY 15 Projected	FY 15 Projected	FY 15 Projected	FY 16 Projected	FY 16 Projected	FY 16 Projected	FY 17 Projected	FY 17 Projected	FY 17 Projected	FY 18 Projected	FY 18 Projected	FY 18 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$18,524,368	$18,612,257		$18,612,257	$17,417,382		$17,417,382	$17,681,644		$17,681,644	$17,681,644		$17,681,644
2	Less: Allowances	$11,987,051	$12,171,075		$12,171,075	$11,318,109		$11,318,109	$11,562,521		$11,562,521	$11,562,521		$11,562,521
3	Less: Charity Care	$6,655	$2,825		$2,825	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$6,530,662**	**$6,438,357**	**$0**	**$6,438,357**	**$6,099,273**	**$0**	**$6,099,273**	**$6,119,123**	**$0**	**$6,119,123**	**$6,119,123**	**$0**	**$6,119,123**
5	Medicare	$4,179,624	$4,120,548		$4,120,548	$3,964,527		$3,964,527	$4,038,621		$4,038,621	$4,038,621		$4,038,621
6	Medicaid	$522,453	$579,452		$579,452	$548,935		$548,935	$611,912		$611,912	$611,912		$611,912
7	CHAMPUS & TriCare	$65,307	$64,384		$64,384	$60,993		$60,993	$61,191		$61,191	$61,191		$61,191
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$4,767,383**	**$4,764,384**	**$0**	**$4,764,384**	**$4,574,455**	**$0**	**$4,574,455**	**$4,711,725**	**$0**	**$4,711,725**	**$4,711,725**	**$0**	**$4,711,725**
9	Commercial Insurers	$1,110,213	$965,754		$965,754	$731,913		$731,913	$611,912		$611,912	$611,912		$611,912
10	Uninsured	$130,613	$128,767		$128,767	$182,978		$182,978	$183,574		$183,574	$183,574		$183,574
11	Self Pay	$326,533	$450,685		$450,685	$487,942		$487,942	$489,530		$489,530	$489,530		$489,530
12	Workers Compensation	$65,307	$64,384		$64,384	$60,993		$60,993	$61,191		$61,191	$61,191		$61,191
13	Other	$130,613	$64,384		$64,384	$60,993		$60,993	$61,191		$61,191	$61,191		$61,191
	Total Non-Government	**$1,763,279**	**$1,673,973**	**$0**	**$1,673,973**	**$1,524,818**	**$0**	**$1,524,818**	**$1,407,398**	**$0**	**$1,407,398**	**$1,407,398**	**$0**	**$1,407,398**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$6,530,662**	**$6,438,357**	**$0**	**$6,438,357**	**$6,099,273**	**$0**	**$6,099,273**	**$6,119,123**	**$0**	**$6,119,123**	**$6,119,123**	**$0**	**$6,119,123**
14	Less: Provision for Bad Debts	$133,571	$193,152		**$193,152**	$182,979		**$182,979**	$193,152		**$193,152**	$193,152		**$193,152**
	Net Patient Service Revenue less provision for bad debts	**$6,397,091**	**$6,245,205**	**$0**	**$6,245,205**	**$5,916,294**	**$0**	**$5,916,294**	**$5,925,971**	**$0**	**$5,925,971**	**$5,925,971**	**$0**	**$5,925,971**
15	Other Operating Revenue	$1,762,014	$1,688,040		**$1,688,040**	$1,483,782		**$1,483,782**	$1,613,040		**$1,613,040**	$1,613,040		**$1,613,040**
17	Net Assets Released from Restrictions	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$8,159,105**	**$7,933,245**	**$0**	**$7,933,245**	**$7,400,076**	**$0**	**$7,400,076**	**$7,539,011**	**$0**	**$7,539,011**	**$7,539,011**	**$0**	**$7,539,011**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$8,789,526	$8,893,185		$8,893,185	$8,291,096		$8,291,096	$8,593,185		$8,593,185	$8,593,185		$8,593,185
2	Fringe Benefits	$1,148,898	$1,192,338		$1,192,338	$1,230,142		$1,230,142	$1,117,338		$1,117,338	$1,117,338		$1,117,338
3	Physicians Fees	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Supplies and Drugs	$85,994	$93,565		$93,565	$96,310		$96,310	$93,565		$93,565	$93,565		$93,565
5	Depreciation and Amortization	$77,732	$76,990		$76,990	$63,240		$63,240	$60,000		$60,000	$60,000		$60,000
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$318,692	$331,882		$331,882	$308,154		$308,154	$331,882		$331,882	$331,882		$331,882
9	Lease Expense	$335,018	$336,711		$336,711	$336,725		$336,725	$336,711		$336,711	$336,711		$336,711
10	Other Operating Expenses	($2,596,755)	($2,991,426)		($2,991,426)	($2,925,591)		($2,925,591)	($2,993,670)		($2,993,670)	($2,993,670)		($2,993,670)
	TOTAL OPERATING EXPENSES	**$8,159,105**	**$7,933,245**	**$0**	**$7,933,245**	**$7,400,076**	**$0**	**$7,400,076**	**$7,539,011**	**$0**	**$7,539,011**	**$7,539,011**	**$0**	**$7,539,011**
	Provision for Income Taxes[c]	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$77,732**	**$76,990**	**$0**	**$76,990**	**$63,240**	**$0**	**$63,240**	**$60,000**	**$0**	**$60,000**	**$60,000**	**$0**	**$60,000**
	INCOME / (LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**($0)**	**$0**	**($0)**	**($0)**	**$0**	**($0)**
	NON-OPERATING INCOME / REVENUE	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**($0)**	**$0**	**($0)**	**($0)**	**$0**	**($0)**
C.	**Retained Earnings / Net Assets, beginning of year**	**$1,815,341**	**$1,815,341**		**$1,815,341**	**$1,815,341**		**$1,815,341**	**$1,815,341**		**$1,815,341**	**$1,815,341**		**$1,815,341**
	Retained Earnings / Net Assets, end of year	**$1,815,341**	**$1,815,341**		**$1,815,341**	**$1,815,341**		**$1,815,341**	**$1,815,341**		**$1,815,341**	**$1,815,341**		**$1,815,341**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Cardiology Associates of GW

Financial Worksheet (C): Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	Principal Payments	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
E.	**FTEs**	**54**	54		**54**	54		**54**	54		**54**	54		**54**
F.	**VOLUME STATISTICS**[d]													
1	Inpatient Discharges	9,392	10,213		**10,213**	9,196		**9,196**	9,696		**9,696**	9,696		**9,696**
2	Outpatient Visits	23,548	23,099		**23,099**	21,249		**21,249**	22,749		**22,749**	22,749		**22,749**
	TOTAL VOLUME	**32,940**	**33,312**	**0**	**33,312**	**30,445**	**0**	**30,445**	**32,445**	**0**	**32,445**	**32,445**	**0**	**32,445**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: GW Imaging Center

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 14 Actual Results	(2) FY 15 Projected W/out CON	(3) FY 15 Projected Incremental	(4) FY 15 Projected With CON	(5) FY 16 Projected W/out CON	(6) FY 16 Projected Incremental	(7) FY 16 Projected With CON	(8) FY 17 Projected W/out CON	(9) FY 17 Projected Incremental	(10) FY 17 Projected With CON	(11) FY 18 Projected W/out CON	(12) FY 18 Projected Incremental	(13) FY 18 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$10,077,378	$9,737,665		$9,737,665	$9,422,020		$9,422,020	$9,460,020		$9,460,020	$9,460,020		$9,460,020
2	Less: Allowances	$5,623,132	$5,839,606		$5,839,606	$5,303,920		$5,303,920	$5,348,020		$5,348,020	$5,348,020		$5,348,020
3	Less: Charity Care	($15,000)	($15,000)		($15,000)	($15,000)		($15,000)	($15,000)		($15,000)	($15,000)		($15,000)
4	Less: Other Deductions	$29,455	$14,836		$14,836	$15,000		$15,000	$15,000		$15,000	$15,000		$15,000
	Net Patient Service Revenue	**$4,439,791**	**$3,898,223**	**$0**	**$3,898,223**	**$4,118,100**	**$0**	**$4,118,100**	**$4,112,000**	**$0**	**$4,112,000**	**$4,112,000**	**$0**	**$4,112,000**
5	Medicare	$976,754	$857,609		$857,609	$864,801		$864,801	$863,520		$863,520	$863,520		$863,520
6	Medicaid	$355,183	$311,858		$311,858	$329,448		$329,448	$328,960		$328,960	$328,960		$328,960
7	CHAMPUS & TriCare	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$1,331,937**	**$1,169,467**	**$0**	**$1,169,467**	**$1,194,249**	**$0**	**$1,194,249**	**$1,192,480**	**$0**	**$1,192,480**	**$1,192,480**	**$0**	**$1,192,480**
9	Commercial Insurers	$1,753,717	$1,539,798		$1,539,798	$1,647,240		$1,647,240	$1,644,800		$1,644,800	$1,644,800		$1,644,800
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$155,393	$136,438		$136,438	$123,543		$123,543	$123,360		$123,360	$123,360		$123,360
12	Workers Compensation	$310,785	$272,876		$272,876	$205,905		$205,905	$205,600		$205,600	$205,600		$205,600
13	Other	$887,958	$779,645		$779,645	$947,163		$947,163	$945,760		$945,760	$945,760		$945,760
	Total Non-Government	**$3,107,854**	**$2,728,756**	**$0**	**$2,728,756**	**$2,923,851**	**$0**	**$2,923,851**	**$2,919,520**	**$0**	**$2,919,520**	**$2,919,520**	**$0**	**$2,919,520**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$4,439,791**	**$3,898,223**	**$0**	**$3,898,223**	**$4,118,100**	**$0**	**$4,118,100**	**$4,112,000**	**$0**	**$4,112,000**	**$4,112,000**	**$0**	**$4,112,000**
14	Less: Provision for Bad Debts	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Net Patient Service Revenue less provision for bad debts	**$4,439,791**	**$3,898,223**	**$0**	**$3,898,223**	**$4,118,100**	**$0**	**$4,118,100**	**$4,112,000**	**$0**	**$4,112,000**	**$4,112,000**	**$0**	**$4,112,000**
15	Other Operating Revenue	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
17	Net Assets Released from Restrictions	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$4,439,791**	**$3,898,223**	**$0**	**$3,898,223**	**$4,118,100**	**$0**	**$4,118,100**	**$4,112,000**	**$0**	**$4,112,000**	**$4,112,000**	**$0**	**$4,112,000**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$710,000	$690,000		$690,000	$698,000		$698,000	$708,000		$708,000	$718,000		$718,000
2	Fringe Benefits	$67,350	$52,350		$52,350	$69,184		$69,184	$74,184		$74,184	$79,000		$79,000
3	Physicians Fees	$674,155	$573,755		$573,755	$620,000		$620,000	$600,000		$600,000	$600,000		$600,000
4	Supplies and Drugs	$342,348	$322,471		$322,471	$340,000		$340,000	$330,000		$330,000	$330,000		$330,000
5	Depreciation and Amortization	$213,716	$192,646		$192,646	$190,000		$190,000	$180,000		$180,000	$170,000		$170,000
6	Provision for Bad Debts-Other[b]	$15,000	$15,000		$15,000	$15,000		$15,000	$15,000		$15,000	$15,000		$15,000
7	Interest Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$30,000	$30,000		$30,000	$30,000		$30,000	$30,000		$30,000	$30,000		$30,000
9	Lease Expense	$105,628	$105,628		$105,628	$105,628		$105,628	$105,628		$105,628	$105,628		$105,628
10	Other Operating Expenses	$759,157	$825,545		$825,545	$937,245		$937,245	$860,000		$860,000	$860,000		$860,000
	TOTAL OPERATING EXPENSES	**$2,917,354**	**$2,807,395**	**$0**	**$2,807,395**	**$3,005,057**	**$0**	**$3,005,057**	**$2,902,812**	**$0**	**$2,902,812**	**$2,907,628**	**$0**	**$2,907,628**
	Provision for Income Taxes[c]	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$1,736,153**	**$1,283,474**	**$0**	**$1,283,474**	**$1,303,043**	**$0**	**$1,303,043**	**$1,389,188**	**$0**	**$1,389,188**	**$1,374,372**	**$0**	**$1,374,372**
	INCOME / (LOSS) FROM OPERATIONS	**$1,522,437**	**$1,090,828**	**$0**	**$1,090,828**	**$1,113,043**	**$0**	**$1,113,043**	**$1,209,188**	**$0**	**$1,209,188**	**$1,204,372**	**$0**	**$1,204,372**
	NON-OPERATING INCOME / REVENUE	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$1,522,437**	**$1,090,828**	**$0**	**$1,090,828**	**$1,113,043**	**$0**	**$1,113,043**	**$1,209,188**	**$0**	**$1,209,188**	**$1,204,372**	**$0**	**$1,204,372**
C	**Retained Earnings / Net Assets, beginning of year**	**$3,538,663**	**$3,267,350**		**$3,267,350**	**$3,155,053**		**$3,155,053**	**$4,268,096**		**$4,268,096**	**$5,477,284**		**$5,477,284**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: GW Imaging Center
Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 14**	**FY 15**	**FY 15**	**FY 15**	**FY 16**	**FY 16**	**FY 16**	**FY 17**	**FY 17**	**FY 17**	**FY 18**	**FY 18**	**FY 18**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**Retained Earnings / Net Assets, end of year**	**$3,267,350**	**$3,155,053**		**$3,155,053**	**$4,268,096**		**$4,268,096**	**$5,477,284**		**$5,477,284**	**$6,681,656**		**$6,681,656**
	Principal Payments	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**34.3%**	**28.0%**	**0.0%**	**28.0%**	**27.0%**	**0.0%**	**27.0%**	**29.4%**	**0.0%**	**29.4%**	**29.3%**	**0.0%**	**29.3%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**34.3%**	**28.0%**	**0.0%**	**28.0%**	**27.0%**	**0.0%**	**27.0%**	**29.4%**	**0.0%**	**29.4%**	**29.3%**	**0.0%**	**29.3%**
E.	**FTEs**	**13**	12		**12**	12		**12**	12		**12**	12		**12**
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0		**0**	0		**0**	0		**0**	0		**0**
2	Outpatient Visits	8,377	7,712		**7,712**	7,844		**7,844**	7,850		**7,850**	7,850		**7,850**
	TOTAL VOLUME	**8,377**	**7,712**	**0**	**7,712**	**7,844**	**0**	**7,844**	**7,850**	**0**	**7,850**	**7,850**	**0**	**7,850**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Access Rehab Centers

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 14 Actual Results	(2) FY 15 Projected W/out CON	(3) FY 15 Projected Incremental	(4) FY 15 Projected With CON	(5) FY 16 Projected W/out CON	(6) FY 16 Projected Incremental	(7) FY 16 Projected With CON	(8) FY 17 Projected W/out CON	(9) FY 17 Projected Incremental	(10) FY 17 Projected With CON	(11) FY 18 Projected W/out CON	(12) FY 18 Projected Incremental	(13) FY 18 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$13,825,075	$14,934,587		$14,934,587	$15,554,805		$15,554,805	$15,788,127		$15,788,127	$16,024,949		$16,024,949
2	Less: Allowances	$5,486,575	$5,984,491		$5,984,491	$6,459,911		$6,459,911	$6,569,440		$6,569,440	$6,686,410		$6,686,410
3	Less: Charity Care	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$8,338,500**	**$8,950,096**	**$0**	**$8,950,096**	**$9,094,894**	**$0**	**$9,094,894**	**$9,218,687**	**$0**	**$9,218,687**	**$9,338,539**	**$0**	**$9,338,539**
5	Medicare	$1,099,940	$1,527,223		$1,527,223	$1,619,574		$1,619,574	$1,641,618		$1,641,618	$1,662,961		$1,662,961
6	Medicaid	$3,393,811	$3,534,922		$3,534,922	$3,645,892		$3,645,892	$3,695,517		$3,695,517	$3,743,562		$3,743,562
7	CHAMPUS & TriCare	$40,633	$39,419		$39,419	$46,380		$46,380	$47,011		$47,011	$47,623		$47,623
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$4,534,384**	**$5,101,564**	**$0**	**$5,101,564**	**$5,311,846**	**$0**	**$5,311,846**	**$5,384,146**	**$0**	**$5,384,146**	**$5,454,146**	**$0**	**$5,454,146**
9	Commercial Insurers	$2,654,252	$2,701,993		$2,701,993	$2,915,467		$2,915,467	$2,955,150		$2,955,150	$2,993,570		$2,993,570
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$35,137	$42,459		$42,459	$29,606		$29,606	$30,009		$30,009	$30,399		$30,399
12	Workers Compensation	$988,123	$1,004,327		$1,004,327	$772,986		$772,986	$783,508		$783,508	$793,694		$793,694
13	Other	$126,604	$99,753		$99,753	$64,989		$64,989	$65,874		$65,874	$66,730		$66,730
	Total Non-Government	**$3,804,116**	**$3,848,532**	**$0**	**$3,848,532**	**$3,783,048**	**$0**	**$3,783,048**	**$3,834,541**	**$0**	**$3,834,541**	**$3,884,393**	**$0**	**$3,884,393**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$8,338,500**	**$8,950,096**	**$0**	**$8,950,096**	**$9,094,894**	**$0**	**$9,094,894**	**$9,218,687**	**$0**	**$9,218,687**	**$9,338,539**	**$0**	**$9,338,539**
14	Less: Provision for Bad Debts	$108,185	$72,942		**$72,942**	$90,949		**$90,949**	$92,187		**$92,187**	$93,385		**$93,385**
	Net Patient Service Revenue less provision for bad debts	**$8,230,315**	**$8,877,155**	**$0**	**$8,877,155**	**$9,003,945**	**$0**	**$9,003,945**	**$9,126,501**	**$0**	**$9,126,501**	**$9,245,154**	**$0**	**$9,245,154**
15	Other Operating Revenue	$2,822,386	$3,037,502		**$3,037,502**	$3,094,330		**$3,094,330**	$3,150,028		**$3,150,028**	$3,206,728		**$3,206,728**
17	Net Assets Released from Restrictions	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$11,052,701**	**$11,914,657**	**$0**	**$11,914,657**	**$12,098,275**	**$0**	**$12,098,275**	**$12,276,528**	**$0**	**$12,276,528**	**$12,451,882**	**$0**	**$12,451,882**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$6,684,283	$7,419,427		$7,419,427	$7,459,925		$7,459,925	$7,646,423		$7,646,423	$7,814,644		$7,814,644
2	Fringe Benefits	$1,345,857	$1,559,453		$1,559,453	$1,766,427		$1,766,427	$1,705,152		$1,705,152	$1,719,222		$1,719,222
3	Physicians Fees	$94,586	$96,954		$96,954	$99,374		$99,374	$101,858		$101,858	$104,405		$104,405
4	Supplies and Drugs	$202,172	$200,432		$200,432	$206,797		$206,797	$209,899		$209,899	$213,047		$213,047
5	Depreciation and Amortization	$110,717	$108,852		$108,852	$100,489		$100,489	$101,996		$101,996	$103,526		$103,526
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$40	$2		$2	$300		$300	$50		$50	$50		$50
8	Malpractice Insurance Cost	$45,568	$46,211		$46,211	$49,326		$49,326	$52,532		$52,532	$55,159		$55,159
9	Lease Expense	$605,327	$612,172		$612,172	$629,244		$629,244	$638,683		$638,683	$648,263		$648,263
10	Other Operating Expenses	$956,248	$941,853		$941,853	$984,140		$984,140	$1,014,517		$1,014,517	$990,596		$990,596
	TOTAL OPERATING EXPENSES	**$10,044,797**	**$10,985,355**	**$0**	**$10,985,355**	**$11,296,022**	**$0**	**$11,296,022**	**$11,471,110**	**$0**	**$11,471,110**	**$11,648,913**	**$0**	**$11,648,913**
	Provision for Income Taxes[c]	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$1,118,661**	**$1,038,155**	**$0**	**$1,038,155**	**$903,042**	**$0**	**$903,042**	**$907,464**	**$0**	**$907,464**	**$906,546**	**$0**	**$906,546**
	INCOME / (LOSS) FROM OPERATIONS	**$1,007,904**	**$929,302**	**$0**	**$929,302**	**$802,253**	**$0**	**$802,253**	**$805,418**	**$0**	**$805,418**	**$802,970**	**$0**	**$802,970**
	NON-OPERATING INCOME / REVENUE	$24,828	$400		**$400**	$0		**$0**	$0		**$0**	$0		**$0**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$1,032,733**	**$929,702**	**$0**	**$929,702**	**$802,253**	**$0**	**$802,253**	**$805,418**	**$0**	**$805,418**	**$802,970**	**$0**	**$802,970**
C	**Retained Earnings / Net Assets, beginning of year**	**$3,946,714**	**$4,192,489**		**$4,192,489**	**$4,121,675**		**$4,121,675**	**$4,923,928**		**$4,923,928**	**$5,729,346**		**$5,729,346**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Access Rehab Centers

Financial Worksheet (C): Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**Retained Earnings / Net Assets, end of year**	**$4,192,489**	**$4,121,675**		**$4,121,675**	**$4,923,928**		**$4,923,928**	**$5,729,346**		**$5,729,346**	**$6,532,316**		**$6,532,316**
	Principal Payments	$2,391	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**9.1%**	**7.8%**	**0.0%**	**7.8%**	**6.6%**	**0.0%**	**6.6%**	**6.6%**	**0.0%**	**6.6%**	**6.4%**	**0.0%**	**6.4%**
2	Hospital Non Operating Margin	**0.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**9.3%**	**7.8%**	**0.0%**	**7.8%**	**6.6%**	**0.0%**	**6.6%**	**6.6%**	**0.0%**	**6.6%**	**6.4%**	**0.0%**	**6.4%**
E.	**FTEs**	**103**	111		**111**	110		**110**	112		**112**	114		**114**
F.	**VOLUME STATISTICS**[d]													
1	Inpatient Discharges	21,753	23,189		**23,189**	22,530		**22,530**	22,530		**22,530**	22,530		**22,530**
2	Outpatient Visits	95,907	102,362		**102,362**	106,154		**106,154**	107,746		**107,746**	109,363		**109,363**
	TOTAL VOLUME	**117,660**	**125,551**	**0**	**125,551**	**128,684**	**0**	**128,684**	**130,276**	**0**	**130,276**	**131,893**	**0**	**131,893**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Imaging Partners

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 14**	**FY 15**	**FY 15**	**FY 15**	**FY 16**	**FY 16**	**FY 16**	**FY 17**	**FY 17**	**FY 17**	**FY 18**	**FY 18**	**FY 18**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0		$0	$0		$0	$0		$0	$0		$0
2	Less: Allowances	$0	$0		$0	$0		$0	$0		$0	$0		$0
3	Less: Charity Care	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0		$0	$0		$0	$0		$0	$0		$0
6	Medicaid	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	CHAMPUS & TriCare	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$0	$0		$0	$0		$0	$0		$0	$0		$0
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$0	$0		$0	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$0	$0		$0	$0		$0	$0		$0	$0		$0
13	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$179,223	$259,924		**$259,924**	$250,424		**$250,424**	$246,146		**$246,146**	$240,604		**$240,604**
17	Net Assets Released from Restrictions	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$179,223**	**$259,924**	**$0**	**$259,924**	**$250,424**	**$0**	**$250,424**	**$246,146**	**$0**	**$246,146**	**$240,604**	**$0**	**$240,604**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0		$0	$0		$0	$0		$0	$0		$0
2	Fringe Benefits	$0	$0		$0	$0		$0	$0		$0	$0		$0
3	Physicians Fees	$394	$48		$48	$0		$0	$0		$0	$0		$0
4	Supplies and Drugs	$1,500	$1,094		$1,094	$1,500		$1,500	$1,530		$1,530	$1,561		$1,561
5	Depreciation and Amortization	$6,034	$2,067		$2,067	$1,788		$1,788	$1,500		$1,500	$1,200		$1,200
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$0	$0		$0	$0		$0	$0		$0	$0		$0
9	Lease Expense	$10,328	$10,692		$10,692	$10,692		$10,692	$10,692		$10,692	$10,692		$10,692
10	Other Operating Expenses	$32,438	$36,593		$36,593	$44,896		$44,896	$46,008		$46,008	$47,142		$47,142
	TOTAL OPERATING EXPENSES	**$50,694**	**$50,494**	**$0**	**$50,494**	**$58,876**	**$0**	**$58,876**	**$59,730**	**$0**	**$59,730**	**$60,595**	**$0**	**$60,595**
	Provision for Income Taxes[c]	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$134,563**	**$211,497**	**$0**	**$211,497**	**$193,336**	**$0**	**$193,336**	**$187,916**	**$0**	**$187,916**	**$181,209**	**$0**	**$181,209**
	INCOME / (LOSS) FROM OPERATIONS	**$128,529**	**$209,430**	**$0**	**$209,430**	**$191,548**	**$0**	**$191,548**	**$186,416**	**$0**	**$186,416**	**$180,009**	**$0**	**$180,009**
	NON-OPERATING INCOME / REVENUE	($14,239)	$1,153		**$1,153**	$1,165		**$1,165**	$1,150		**$1,150**	$1,150		**$1,150**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$114,290**	**$210,583**	**$0**	**$210,583**	**$192,713**	**$0**	**$192,713**	**$187,566**	**$0**	**$187,566**	**$181,159**	**$0**	**$181,159**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Imaging Partners

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 14**	**FY 15**	**FY 15**	**FY 15**	**FY 16**	**FY 16**	**FY 16**	**FY 17**	**FY 17**	**FY 17**	**FY 18**	**FY 18**	**FY 18**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**Retained Earnings / Net Assets, beginning of year**	**$370,223**	**$484,513**		**$484,513**	**$595,096**		**$595,096**	**$787,809**		**$787,809**	**$975,375**		**$975,375**
	Retained Earnings / Net Assets, end of year	**$484,513**	**$595,096**		**$595,096**	**$787,809**		**$787,809**	**$975,375**		**$975,375**	**$1,156,534**		**$1,156,534**
	Principal Payments	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**77.9%**	**80.2%**	**0.0%**	**80.2%**	**76.1%**	**0.0%**	**76.1%**	**75.4%**	**0.0%**	**75.4%**	**74.5%**	**0.0%**	**74.5%**
2	Hospital Non Operating Margin	**-8.6%**	**0.4%**	**0.0%**	**0.4%**	**0.5%**	**0.0%**	**0.5%**	**0.5%**	**0.0%**	**0.5%**	**0.5%**	**0.0%**	**0.5%**
3	Hospital Total Margin	**69.3%**	**80.7%**	**0.0%**	**80.7%**	**76.6%**	**0.0%**	**76.6%**	**75.8%**	**0.0%**	**75.8%**	**74.9%**	**0.0%**	**74.9%**
E.	**FTEs**	**0**	0		**0**	0		**0**	0		**0**	0		**0**
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0		**0**	0		**0**	0		**0**	0		**0**
2	Outpatient Visits	0	0		**0**	0		**0**	0		**0**	0		**0**
	TOTAL VOLUME	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: VNA

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14 Actual Results	FY 15 Projected W/out CON	FY 15 Projected Incremental	FY 15 Projected With CON	FY 16 Projected W/out CON	FY 16 Projected Incremental	FY 16 Projected With CON	FY 17 Projected W/out CON	FY 17 Projected Incremental	FY 17 Projected With CON	FY 18 Projected W/out CON	FY 18 Projected Incremental	FY 18 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$5,620,392	$5,979,640		$5,979,640	$6,158,989		$6,158,989	$6,282,169		$6,282,169	$6,407,812		$6,407,812
2	Less: Allowances	$1,053,835	$966,324		$966,324	$939,507		$939,507	$958,297		$958,297	$977,463		$977,463
3	Less: Charity Care	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$4,566,557**	**$5,013,316**	**$0**	**$5,013,316**	**$5,219,482**	**$0**	**$5,219,482**	**$5,323,872**	**$0**	**$5,323,872**	**$5,430,349**	**$0**	**$5,430,349**
5	Medicare	$3,328,686	$3,558,096		$3,558,096	$3,615,300		$3,615,300	$3,687,606		$3,687,606	$3,761,358		$3,761,358
6	Medicaid	$340,546	$299,573		$299,573	$297,694		$297,694	$303,648		$303,648	$309,721		$309,721
7	CHAMPUS & TriCare	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	**$3,669,232**	**$3,857,669**	**$0**	**$3,857,669**	**$3,912,994**	**$0**	**$3,912,994**	**$3,991,254**	**$0**	**$3,991,254**	**$4,071,079**	**$0**	**$4,071,079**
9	Commercial Insurers	$719,535	$988,359		$988,359	$1,140,000		$1,140,000	$1,162,800		$1,162,800	$1,186,056		$1,186,056
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$23,970	$27,113		$27,113	$33,000		$33,000	$33,660		$33,660	$34,333		$34,333
12	Workers Compensation	$31,674	$31,270		$31,270	$26,400		$26,400	$26,928		$26,928	$27,467		$27,467
13	Other	$122,146	$108,905		$108,905	$107,088		$107,088	$109,230		$109,230	$111,414		$111,414
	Total Non-Government	**$897,325**	**$1,155,647**	**$0**	**$1,155,647**	**$1,306,488**	**$0**	**$1,306,488**	**$1,332,618**	**$0**	**$1,332,618**	**$1,359,270**	**$0**	**$1,359,270**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$4,566,557**	**$5,013,316**	**$0**	**$5,013,316**	**$5,219,482**	**$0**	**$5,219,482**	**$5,323,872**	**$0**	**$5,323,872**	**$5,430,349**	**$0**	**$5,430,349**
14	Less: Provision for Bad Debts	$26,865	$7,815		**$7,815**	$24,000		**$24,000**	$24,480		**$24,480**	$24,970		**$24,970**
	Net Patient Service Revenue less provision for bad debts	**$4,539,692**	**$5,005,501**	**$0**	**$5,005,501**	**$5,195,482**	**$0**	**$5,195,482**	**$5,299,392**	**$0**	**$5,299,392**	**$5,405,379**	**$0**	**$5,405,379**
15	Other Operating Revenue	$97,936	$83,679		**$83,679**	$85,880		**$85,880**	$87,598		**$87,598**	$89,350		**$89,350**
17	Net Assets Released from Restrictions	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$4,637,628**	**$5,089,180**	**$0**	**$5,089,180**	**$5,281,362**	**$0**	**$5,281,362**	**$5,386,989**	**$0**	**$5,386,989**	**$5,494,729**	**$0**	**$5,494,729**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$2,504,779	$2,773,662		$2,773,662	$3,103,598		$3,103,598	$3,165,670		$3,165,670	$3,228,983		$3,228,983
2	Fringe Benefits	$473,498	$520,566		$520,566	$714,160		$714,160	$728,443		$728,443	$743,012		$743,012
3	Physicians Fees	$0	$0		$0	$0		$0	$0		$0	$0		$0
4	Supplies and Drugs	$92,521	$117,270		$117,270	$117,000		$117,000	$119,340		$119,340	$121,727		$121,727
5	Depreciation and Amortization	$56,028	$29,658		$29,658	$36,000		$36,000	$36,720		$36,720	$37,454		$37,454
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$0	$0		$0	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$11,567	$16,087		$16,087	$14,400		$14,400	$14,688		$14,688	$14,982		$14,982
9	Lease Expense	$100,000	$100,000		$100,000	$100,000		$100,000	$102,000		$102,000	$104,040		$104,040
10	Other Operating Expenses	$1,015,646	$1,028,395		$1,028,395	$976,204		$976,204	$995,728		$995,728	$1,015,643		$1,015,643
	TOTAL OPERATING EXPENSES	**$4,254,039**	**$4,585,638**	**$0**	**$4,585,638**	**$5,061,362**	**$0**	**$5,061,362**	**$5,162,589**	**$0**	**$5,162,589**	**$5,265,841**	**$0**	**$5,265,841**
	Provision for Income Taxes[c]	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$439,617**	**$533,200**	**$0**	**$533,200**	**$256,000**	**$0**	**$256,000**	**$261,120**	**$0**	**$261,120**	**$266,342**	**$0**	**$266,342**
	INCOME / (LOSS) FROM OPERATIONS	**$383,589**	**$503,542**	**$0**	**$503,542**	**$220,000**	**$0**	**$220,000**	**$224,400**	**$0**	**$224,400**	**$228,888**	**$0**	**$228,888**
	NON-OPERATING INCOME / REVENUE	$127,561	$ 44,346		**$44,346**	$ 30,000		**$30,000**	$30,600		**$30,600**	$31,212		**$31,212**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$511,150**	**$547,888**	**$0**	**$547,888**	**$250,000**	**$0**	**$250,000**	**$255,000**	**$0**	**$255,000**	**$260,100**	**$0**	**$260,100**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: VNA

Financial Worksheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 14**	**FY 15**	**FY 15**	**FY 15**	**FY 16**	**FY 16**	**FY 16**	**FY 17**	**FY 17**	**FY 17**	**FY 18**	**FY 18**	**FY 18**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**Retained Earnings / Net Assets, beginning of year**	**$1,849,057**	**$2,360,207**		**$2,360,207**	**$2,908,095**		**$2,908,095**	**$3,158,095**		**$3,158,095**	**$3,413,095**		**$3,413,095**
	Retained Earnings / Net Assets, end of year	**$2,360,207**	**$2,908,095**		**$2,908,095**	**$3,158,095**		**$3,158,095**	**$3,413,095**		**$3,413,095**	**$3,673,195**		**$3,673,195**
	Principal Payments	$0	$0		**$0**	$0		**$0**	$0		**$0**	$0		**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**8.0%**	**9.8%**	**0.0%**	**9.8%**	**4.1%**	**0.0%**	**4.1%**	**4.1%**	**0.0%**	**4.1%**	**4.1%**	**0.0%**	**4.1%**
2	Hospital Non Operating Margin	**2.7%**	**0.9%**	**0.0%**	**0.9%**	**0.6%**	**0.0%**	**0.6%**	**0.6%**	**0.0%**	**0.6%**	**0.6%**	**0.0%**	**0.6%**
3	Hospital Total Margin	**10.7%**	**10.7%**	**0.0%**	**10.7%**	**4.7%**	**0.0%**	**4.7%**	**4.7%**	**0.0%**	**4.7%**	**4.7%**	**0.0%**	**4.7%**
E.	**FTEs**	**36**	**38**		**38**	**42**		**42**	**43**		**43**	**44**		**44**
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	$0	$0		**0**	$0		**0**	$0		**0**	$0		**0**
2	Outpatient Visits	34,845	37,276		**37,276**	38,000		**38,000**	38,760		**38,760**	39,515		**39,515**
	TOTAL VOLUME	**34,845**	**37,276**	**0**	**37,276**	**38,000**	**0**	**38,000**	**38,760**	**0**	**38,760**	**39,515**	**0**	**39,515**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Per Affiliate worksheets:

	FY14	FY15	FY16	FY17	FY18
ARC			521,464		
GWIC			712,348		
Imaging Partners			163,807		
AMG	(8,152,669)	(8,891,112)	(7,485,718)	(7,485,718)	(7,485,718)
CAGW	(3,143,116)	(3,564,981)	(3,696,333)	(3,729,372)	(3,729,372)
	(11,295,785)	(12,456,093)			

Greer, Leslie

From: Greer, Leslie
Sent: Friday, March 04, 2016 11:11 AM
To: Ann H. Zucker (AZucker@carmodylaw.com); 'mmv@bvmlaw.com'; 'jonathan.spees@prospectmedical.com'; dstromstad@wtbyhosp.org
Cc: Hawes, Gary W.; Lazarus, Steven; Cotto, Carmen; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: Docket Number 15-32017-486 and 15-486-02 Deemed Complete
Attachments: 32017 Deemed Complete.pdf

Tracking:

Recipient	Delivery
Ann H. Zucker (AZucker@carmodylaw.com)	
'mmv@bvmlaw.com'	
'jonathan.spees@prospectmedical.com'	
dstromstad@wtbyhosp.org	
Hawes, Gary W.	Delivered: 3/4/2016 11:12 AM
Lazarus, Steven	Delivered: 3/4/2016 11:12 AM
Cotto, Carmen	Delivered: 3/4/2016 11:12 AM
Riggott, Kaila	Delivered: 3/4/2016 11:12 AM
Hansted, Kevin	Delivered: 3/4/2016 11:12 AM
Martone, Kim	Delivered: 3/4/2016 11:12 AM

Good Morning,
Please see the attached Deemed Complete letter for Greater Waterbury Health Network, Inc.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

March 4, 2016

VIA ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Darlene Stromstad, FACHE
President/CEO
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06708

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02

Dear Ms. Stromstad and Mr. Spees:

This letter is to inform you that, pursuant to § 19a-486a (e) of the Connecticut General Statutes, the Office of the Attorney General ("OAG") and the Department of Public Health, Office of Health Care Access ("DPH") have jointly deemed the above-referenced Application complete as of March 3, 2016.

Please be advised that although the Application is being deemed complete, the OAG and DPH reserve the right to seek additional information or filings as necessary to review and make a determination on this Application.

If you have any questions regarding this matter, please feel free to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General

Very truly yours,

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

cc: Steven Lazarus, OAG (via electronic mail)
Gary W. Hawes, OAG (via electronic mail)
Counsel of Record (via electronic mail)

Greer, Leslie

From: Martone, Kim
Sent: Monday, April 04, 2016 3:42 PM
To: Hansted, Kevin; Lazarus, Steven
Cc: Greer, Leslie
Subject: FW: Petitions to OCHA regarding waterbury hearing on waterbury hospital
Attachments: petition to ocha for waterbury hearing on waterbury hospital 2.0.JPG; petition to ocha for waterbury hearing on waterbury hospital.JPG

From: steven schrag [mailto:stevenschrag@comcast.net]
Sent: Monday, April 04, 2016 3:02 PM
To: Martone, Kim
Cc: Alex Renesko; 'AngelaAybar'; Bonnie Ordione; Cooney, John; Danny Blinderman; IVP Gmail; JVergauwen@snet.net; kit salazaar smith; nvp@conversent.net; 'ramona barnes'; Rev. Lionel French
Subject: Petitions to OCHA regarding waterbury hearing on waterbury hospital

Dear Ms. Martone,

Attached are petitions asking OCHA to hold the Waterbury hearing at a convenient time in the evening and on another day other than presidential primary day.

Thank you for your time and consideration.

Sincerely,

Steve Schrag
Community United

Community petition for public hearing on Waterbury Hospital's future

Under Connecticut statute Section 19a-639a, we the undersigned request that Kimberly Martone of the Connecticut Department of Public Health hold a public hearing on the proposed certificate of need application for Prospect Medical Holdings acquiring Greater Waterbury Health Network (Waterbury Hospital) in Waterbury.

This should not be done on April 26, 2026 (which is presidential primary day) and should be held in the evening so that the working public can attend and contribute to the discussion about this important process.

Name	Address
Edward A. Heaton	101 Tait pt Unit 4 Waterbury, CT 06705
Stephen F. Wierbicki	51 Concord Street East Hartford, CT 06108
ARNOLD J. PERROTTA	206 PEEN ACRES TRUMBULL, CT. 06611
Karen D. Schumaker	46 Birdsall Ave. Trumbull, Ct. 06611
Christina A. Pina	109 Aldbourne Dr. Bristol CT 06010
Maylene J. Ortiz	5 Windsor Pl. Naugatuck, Ct. 06770
Kit Salazar-Smith	392 Hill St Waterbury, CT 06704
Pamela LaRosa	904 Woodruff St Southington, CT 06489
Claudie Arseneault	45 Loop Rd Waterford CT 06795
Carmencita M DeAguiar	127 Madison St CT 06706

Community United for Jobs, Healthcare and Opportunity
c/o NVP 16 Church Street Waterbury, CT 06702

Community petition for public hearing on Waterbury Hospital's future

Under Connecticut statute Section 19a-639a, we the undersigned request that Kimberly Martone of the Connecticut Department of Public Health hold a public hearing on the proposed certificate of need application for Prospect Medical Holdings acquiring Greater Waterbury Health Network (Waterbury Hospital) in Waterbury.

This should not be done on April 26, 2026 (which is presidential primary day) and should be held in the evening so that the working public can attend and contribute to the discussion about this important process.

Name	Address
Shauna Delvecchio	37 Frances Dr Seymour CT
	61 Delhurst Dr. Waterbury, CT
Judi Carl	75 Ash Dr Hamden Ct
Tom Fan	11 MILLS AVE., MILFORD CT
Wayne Mallett	70 AUDI LN., STRATFORD, CT
Robert Egan	94 KENDALL CIR WATERBURY CT 06705
	392 Hill St. Waterbury, CT
Isaac Bonnie, Diana	131 Lakeside Ave Waterbury CT 06708
	175 Cleveland Ave Wby, CT 710
Steve Schnog	14 QUENTIN ST WTBY CT

Community United for Jobs, Healthcare and Opportunity
c/o NVP 16 Church Street Waterbury, CT 06702

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 12, 2016 10:47 AM
To: Greer, Leslie
Subject: FW: Emailing: 2016-04-08 GWHN - Notice of Public Hearing.pdf, 2016-04-08 GWHN ltr re Notice of Public Hearing.pdf [CTAG-CTAG.FID647717]
Attachments: 2016-04-08 GWHN - Notice of Public Hearing.pdf; 2016-04-08 GWHN ltr re Notice of Public Hearing.pdf

Please add to the record and OHCA Calendar.

Thanks,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

-----Original Message-----
From: Turner, Cheryl A.
Sent: Friday, April 08, 2016 2:30 PM
To: Stromstad, Darlene; jonathan.spees@prospectmedical.com
Cc: mmv@bvmlaw.com; AZucker@carmodylaw.com; Salton, Henry A.; Zinn-Rowthorn, Perry A.; Hansted, Kevin; Lazarus, Steven; Hawes, Gary W.
Subject: FW: Emailing: 2016-04-08 GWHN - Notice of Public Hearing.pdf, 2016-04-08 GWHN ltr re Notice of Public Hearing.pdf [CTAG-CTAG.FID647717]

Dear Ms. Stromstad and Mr. Spees,

On behalf of Assistant Attorney General Gary Hawes, I am forwarding to you a letter regarding the May 3, 2016 GWHN/Prospect Medical Holdings Public Hearing along with a copy of the notice that will be published in the Waterbury Republican-American newspaper on Monday, April 11, 2016. Should you have any questions regarding the attached, please contact either me or Attorney Hawes.

Thank you,

Cheryl A. Turner
Paralegal Specialist
Office of the Attorney General
55 Elm Street

GEORGE JEPSEN
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of the Attorney General
State of Connecticut

April 8, 2016

Darlene Stromstad, FACHE
President/CEO
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06708

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02

Dear Ms. Stromstad and Mr. Spees,

With the receipt of the application information submitted to our offices, the Office of the Attorney General and the Office of Health Care Access have initiated a review of the above proposal involving the sale of a nonprofit hospital to a for profit entity filed pursuant to Conn. Gen. Stat. § 19a-486a.

Pursuant to Conn. Gen. Stat. § 19a-486e, prior to making any decision to approve or disapprove a proposed agreement requiring notice under Conn. Gen. Stat. § 19a-486a, the Attorney General and the Commissioner of the Office of Health Care Access shall jointly conduct one or more public hearings, one of which shall be in the primary service area of the nonprofit hospital. This public hearing notice is being issued pursuant to Conn. Gen. Stat. § 19a-486e.

Notice is hereby given of a public hearing to commence on:

Date: May 3, 2016

Time: 1:00 p.m.

Place: Courtyard by Marriott Waterbury
Grand Ballroom
63 Grand Street
Waterbury, CT 06702

The Applicants are designated as parties to this proceeding.

Pursuant to Section 19a-9-29(e) of the Regulations of Connecticut State Agencies, the Office of the Attorney General and the Office of Health Care Access hereby require the Applicants to prefile in written form all information that they propose to present at the public hearing to be held on May 3, 2016, no later than April 26, 2016.

Any interested persons may petition the Office of the Attorney General and/or the Office of Health Care Access for status in the proceedings in accordance with the provisions of the Conn. Gen. Stat. § 4-177a et seq.

Enclosed for your information is a copy of the public hearing notice to be published under legal notices in The Republican-American pursuant to Conn. Gen. Stat. § 19a-486e.

Sincerely,

Kimberly R. Martone
Director of Operations
Office of Health Care Access

Gary W. Hawes
Assistant Attorney General
Office of the Attorney General

Enclosure

cc: Ann Zucker, Esq., Carmody Torrance Sandak Hennessey, LLP
Michelle Volpe, Bershtein Volpe & McKeon
Henry Salton, Esq., Office of the Attorney General
Perry Zinn Rowthorn, Esq., Office of the Attorney General
Kevin Hansted, Department of Public Health
Steven Lazarus, Department of Public Health

GEORGE JEPSEN
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of the Attorney General
State of Connecticut

April 8, 2016

VIA ELECTRONIC MAIL
Republican-American
389 Meadow Street, P.O. Box 2090
Waterbury, Connecticut 06722-2090

Re: Greater Waterbury Health Network, Inc.

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, April 11, 2016.** 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 you have any questions regarding this legal notice, please contact Cheryl Turner at (860) 808-5020.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Very truly yours,

Gary W. Hawes
Assistant Attorney General

Enclosure

Republican-American **April 8, 2016**
Notice of Public Hearing: OAG Docket No. 15-486-02,
OHCA Docket No. 15-31217-486

PLEASE INSERT THE FOLLOWING:

Office of the Attorney General and Office of Health Care Access Public Hearing

Statute Reference:	Conn. Gen. Stat. § 19a-486e
Applicant(s):	Greater Waterbury Health Network, Inc. Prospect Medical Holdings, Inc.
Town:	Waterbury
Docket Numbers:	OHCA Docket No. 15-31217-486 and Attorney General Docket No. 15-486-02
Proposal:	Greater Waterbury Health Network, Inc. ("GWHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of GWHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay approximately $45,000,000 for the assets of GWHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $55,000,000 on capital items for the hospital and service area of Waterbury Hospital, over five years.
Date:	May 3, 2016, and to anytime thereafter as may be necessary
Time:	1:00 p.m.
Place:	Courtyard by Marriot Waterbury Grand Ballroom 63 Grand Street Waterbury, Connecticut

Any person who wishes to request status as a party or an intervenor in the above listed public hearing may file a written petition with a written copy of their intended testimony to the Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG") no later than close of business on April 28, 2016, pursuant to Conn. Gen. Stat. § 4-177a and §§ 19a-9-26 and 19a-9-27 of the Regulations of Connecticut State Agencies. OHCA and the OAG shall rule on the petitions after the April 28, 2016, deadline. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, April 13, 2016 3:33 PM
To: Ann H. Zucker; Michele Volpe (mmv@bvmlaw.com)
Cc: Hawes, Gary W.; Hansted, Kevin; Martone, Kim; Riggott, Kaila; Greer, Leslie; Olejarz, Barbara; Turner, Cheryl A.
Subject: Emailing - DNs 15-32017-486 and 15-486-02 GWHN & PMH Request for Prefile and Issues.pdf
Attachments: DNs 15-32017-486 and 15-486-02 GWHN & PMH Request for Prefile and Issues.pdf

Good Afternoon Ann and Michele,

Attached is the Request for Prefile Testimony and Issues related to the Greater Waterbury Health Network and Prospect Medical Holdings' public hearing scheduled on May 3rd in Waterbury. If you have any questions, please do not hesitate to contact Gary Hawes (Gary.Hawes@ct.gov) or me.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

April 13, 2016

Via Email Only

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Darlene Stromstad, FACHE
President/CEO
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06708

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02
Request for Prefiled Testimony and Issues

Dear Mr. Spees and Ms. Stromstad:

The Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG") will hold a public hearing on the above docket number on May 3, 2016. The hearing will begin at 1:00 p.m. on at the Courtyard by Marriot Waterbury, Grand Ballroom, 63 Grand Street Waterbury, CT. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA and the OAG request that Greater Waterbury Health Network, Inc and Prospect Medical Holdings, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on April 26, 2016.

Additionally, please find attached Issues. Please respond to the attached Issues in writing to OHCA and OAG as an attachement to the Prefile testimony.

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.

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

Please contact Gary A. Hawes (Gary.Hawes@ct.gov or (860) 808-5020) or Steven W. Lazarus (Steven.lazarus@ct.gov or (860) 418-7012) if you have any questions concerning this request.

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Gary A. Hawes
Assistant Attorney General
Office of the Attorney General

Attachment

Cc: Ann Zucker, Esq.
Michelle Volpe, Esq.

ISSUES

Office of Health Care Access Docket No. 15-32017-486
Attorney General Docket No. 15-486-02

Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.

The Applicants should be prepared to present and discuss supporting evidence on the following issues:

- The clear public need for and the community benefits of the proposal.
- How access to care will be maintained in the service area following the purchase of Greater Waterbury Health Network, Inc.'s ("GWHN") assets, including Waterbury Hospital, by Prospect Medical Holdings, Inc. ("PMH").
- PMH's management of Quality Assurance and Performance Improvement (QAPI) across its hospital network and, in particular, the manner in which oversight of the QAPI program will be managed at Waterbury Hospital.
- The roles and responsibilities of PMH's Chief Quality Officer, Chief Clinical Officer, Senior Chief Nursing Officer and VP of Regulatory and Patient Safety in overseeing the QAPI program across its hospital network, and, in particular, Waterbury Hospital, as well as the role and responsibilities of the Hospital Board and Local Board (as those terms are defined in the Application) for management of QAPI at Waterbury Hospital post-closing.
- The financial feasibility of the proposal.
- How prices for, and the cost of, health care services at Waterbury Hospital will be affected by PMH's acquisition.
- The charity care policies to be implemented at Waterbury Hospital following the transfer of ownership and how they compare to PMH's current charity care policies.
- The commitment PMH is willing to make to performing future health needs assessments for the communities in GWHN's service area in a manner that allows for widespread public input, collaboration with other health care providers in the community as well public dissemination of the assessments and Waterbury's implementation plan to address the identified needs.
- The expected timing of the creation of the Independent Foundation, its basis for 501(c)(3) status, and the timing and content of the approximation actions for those charitable funds restricted as to use and those funds whose unrestricted income can and will be used to pay off GWHN liabilities post close.

Provide a written response on the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the Application completeness process:

1. With respect to PMH's recent acquisition of East Orange General Hospital in New Jersey, please describe the financial terms of that transaction, including without limitation, the purchase price and amount and duration of any capital commitments. Please also describe the funding sources used by PMH to pay the purchase price and those that will be used to fund any capital commitments or other material financial obligations of PMH at East Orange General Hospital.

2. PMH has entered into an agreement to buy Crozer-Keystone Health System in Pennsylvania. Under the reported terms of the agreement, PMH is pledging to keep all five Crozer-Keystone hospitals open and invest $200 million in the medical centers over the next five years in capital commitments as well as assuming Crozer-Keystone's outstanding pension liability of $100 million. Please provide an update on the status of this proposed acquisition addressing, in particular:

    a. the financial terms of the transaction;

    b. PMH's plan to fund the purchase price, capital commitment, pension liabilities and other material financial obligations associated with the transaction;

    c. the status of any necessary governmental or non-governmental approvals connected with the transaction;

    d. the anticipated closing date; and

    e. the impact that the transaction will have on PMH's ability to meet its financial commitments in connection with the proposed GWHN and ECHN asset purchases in Connecticut.

3. With respect to the surveys of PMH's Southern California Hospitals completed on 4/21/14, 8/21/14, 9/25/15 and 12/22/15 as well as the survey of Los Angeles Community Hospital ("LACH") completed on 11/10/15 that resulted in the California Department of Health declaring Immediate Jeopardy situations to exist, please identify when GWHN first learned of each Immediate Jeopardy determination. Please also discuss GWHN's due diligence after having learned about the Immediate Jeopardy determinations and the conclusions based upon that due diligence.

4. Please provide an update on the status of any subsequent surveys and findings of the CDOH with respect to the Statement of Deficiencies issues in connection with the 12/22/15 of Southern California Hospital at Culver City and the March 23, 2016 letter to LACH informing LACH that it continues to be out of compliance with respect to the CMS Conditions of Participation for hospitals in the areas of Nursing Services and Infection Control.

5. In the Application at page 84, PMH has committed to continue to provide financial support for community building activities in the Waterbury area. Particular community services and benefits currently provided by Waterbury Hospital, such as the Food for Life Program, are possible via funding through state, federal, or private grants. Please describe the extent to which GWHN has explored its ability to keep these programs grant funded if Waterbury Hospital is converted to for profit status and any role the Independent Foundation being formed as a part of this proposal might play in sustaining any grant-funded activities.

6. With respect to page 1465 of Applicants' February 16, 2016 responses to completeness questions (the "Second Set of Completeness Responses"), please elaborate on the specific circumstances that contributed to the declines in inpatient and outpatient surgical cases between FY 14 and FY 15 and the overall decline in total outpatient cases over the same period which led to a deficit in revenues over expenses of $21,995,334 in FY 15 -- a deficit increase of approximately $15.7 million for Waterbury Hospital over the prior fiscal year. In addition, please discuss the current profitability of Waterbury Hospital and how the Applicants intend to address these declines in volume and net patient service revenue post-closing.

7. With respect to Exhibit Q5-1, page 1479, of the Second Set of Completeness Responses and the Long Term Debt to Equity ratio for PMH:

    a. Please explain the ratio's downward trend from a negative 37.0 in FYTD 7/31/14 to an even higher negative ratio of 349.8 in FYTD 9/30/14; and

    b. elaborate on the steps or initiatives taken that contributed to the ratio's increase between FYTD 9/30/14 and FYTD 9/30/15 from a negative 349.8 to a positive 11.6.

8. In reference to the Financial Worksheets submitted as Exhibit Q6a-1 to the Second Set of Completeness Responses, please explain the zero incremental gains/losses associated with this proposal for GWHN when in Applicants' initial October 28, 2015 submission, pps. 1167-68, a Financial Worksheet for GWHN was submitted that included incremental amounts associated with this proposal.

9. Provide annual cash flow that would be generated and become available to support capital projects over the next five years at Waterbury Hospital as a result of PMH's addressing GWHN's debt and pension obligations.

10. Please provide a list of critical, immediate (over next 2-3 years) capital needs at The Waterbury Hospital.

11. Please provide a complete description of the Local Board, including, but not limited to, its composition, the process for appointment and replacement of members of the Local Board, and how it will function regarding oversight of quality assurance in conjunction with the Hospital Board and PMH's corporate quality team.

Olejarz, Barbara

From: Martone, Kim
Sent: Wednesday, April 27, 2016 2:24 PM
To: Olejarz, Barbara
Subject: FW: Greater Waterbury Health Network, Inc. and Prospect Medical Holidngs, Inc. Request for Extension of Time

---

From: Anne D. Peterson [mailto:APeterson@carmodylaw.com]
Sent: Tuesday, April 26, 2016 3:06 PM
To: Hawes, Gary W.; Lazarus, Steven; Martone, Kim; Hansted, Kevin
Cc: Ann H. Zucker; mmv@bvmlaw.com; Kathleen Gedney (kgg@bvmlaw.com)
Subject: Greater Waterbury Health Network, Inc. and Prospect Medical Holidngs, Inc. Request for Extension of Time

Dear Gary, Steve, Kevin and Kimberly - this office represents Greater Waterbury Health Network, Inc. in the proposed Asset Purchase by Prospect Medical Holdings, Inc. The applicants' prefile testimony is due to be filed today (OHCA Docket Number 15-32017-486 and Attorney General Docket Number 15-486-02). We are finalizing our filing, but would like to request a one-day extension in order to do so. Prospect Medical Holdings, Inc. does not oppose this extension. Thank you for your consideration. Please let me know if this is ok. Thank you.

Anne D. Peterson

Anne D. Peterson | Bio
Carmody Torrance Sandak & Hennessey LLP
195 Church Street | P.O. Box 1950
New Haven, CT 06509-1950
Direct: 203-784-3104 | Fax: 203-784-3199
APeterson@carmodylaw.com | www.carmodylaw.com

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HTML

Olejarz, Barbara

From: Martone, Kim
Sent: Wednesday, April 27, 2016 2:23 PM
To: Olejarz, Barbara
Subject: FW: Greater Waterbury Health Network, Inc. and Prospect Medical Holidngs, Inc. Request for Extension of Time [CTAG-CTAG.FID647717]

From: Hawes, Gary W.
Sent: Tuesday, April 26, 2016 4:11 PM
To: Anne D. Peterson; Lazarus, Steven; Martone, Kim; Hansted, Kevin
Cc: Ann H. Zucker; mmv@bvmlaw.com; Kathleen Gedney (kgg@bvmlaw.com)
Subject: RE: Greater Waterbury Health Network, Inc. and Prospect Medical Holidngs, Inc. Request for Extension of Time [CTAG-CTAG.FID647717]

Anne,

Your request for a one-day extension for the pre-filed testimony is granted. Sorry for the delayed response.

Gary

Gary W. Hawes | Assistant Attorney General | Office of the Attorney General
55 Elm Street | P.O. Box 120 | Hartford Connecticut 06106
T: 860.808.5020 | F: 860.808.5347 | gary.hawes@ct.gov

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From: Anne D. Peterson [mailto:APeterson@carmodylaw.com]
Sent: Tuesday, April 26, 2016 3:06 PM
To: Hawes, Gary W.; Lazarus, Steven; Martone, Kim; Hansted, Kevin
Cc: Ann H. Zucker; mmv@bvmlaw.com; Kathleen Gedney (kgg@bvmlaw.com)
Subject: Greater Waterbury Health Network, Inc. and Prospect Medical Holidngs, Inc. Request for Extension of Time

Dear Gary, Steve, Kevin and Kimberly - this office represents Greater Waterbury Health Network, Inc. in the proposed Asset Purchase by Prospect Medical Holdings, Inc. The applicants' prefile testimony is due to be filed today (OHCA Docket Number 15-32017-486 and Attorney General Docket Number 15-486-02). We are finalizing our filing, but would like to request a one-day extension in order to do so. Prospect Medical Holdings, Inc. does not oppose this extension. Thank you for your consideration. Please let me know if this is ok. Thank you.

Anne D. Peterson

Anne D. Peterson | Bio
Carmody Torrance Sandak & Hennessey LLP
195 Church Street | P.O. Box 1950

New Haven, CT 06509-1950
Direct: 203-784-3104 | Fax: 203-784-3199
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HTML

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Ann H. Zucker
Partner
Direct: 203.252.2652
Fax: 203.325.8608
azucker@carmodylaw.com

707 Summer Street
Stamford, CT 06901

April 27, 2016

VIA HAND DELIVERY

Office of the Attorney General
55 Elm St.
P.O. Box 120
Hartford, CT 06141-0120
Attn: Atty. Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capital Avenue
Hartford, CT 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32017-486 and Attorney General Docket Number: 15-486-02

Dear Mr. Hawes and Mr. Lazarus:

Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. hereby submit the following:

1. Responses to the issues identified in the letter dated April 13, 2016 from the Office of the Attorney General and the Office of Health Care Access (the "Hearing Notice").

2. Prefile testimony of the following individuals, each of whom will be present at the hearing scheduled for May 3, 2016, and will be available for questions:

   For Greater Waterbury Health Network, Inc.:

   Carl Contadini
   Darlene Stromstad
   Carl Sherter, M.D.
   James Moylan

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

For Prospect Medical Holdings, Inc.:

Von Crockett
Mitchell Lew, M.D.
Jonathan Spees
Steven Aleman

As requested, the prefile testimony addresses the topics identified in the Hearing Notice. Please find below a chart that shows which speaker's testimony addresses each of the topics identified:

Topic	Prefile Testimony
1. The clear public need for and the community benefits of the proposal.	All
2. How access to care will be maintained in the service area following the purchase of Greater Waterbury Health Network, Inc.'s ("GWHN") assets, including Waterbury Hospital, by Prospect Medical Holdings, Inc. ("PMH").	All, but particularly the testimony of Mitchell Lew, M.D. and Jonathan Spees
3. PMH's management of Quality Assurance and Performance Improvement (QAPI) across its hospital network and, in particular, the manner in which oversight of the QAPI program will be managed at Waterbury Hospital.	Testimony of Von Crockett
4. The roles and responsibilities of PMH's Chief Quality Officer, Chief Clinical Officer, Senior Chief Nursing Officer and VP of Regulatory and Patient Safety in overseeing the QAPI program across its hospital network, and, in particular, Waterbury Hospital, as well as the role and responsibilities of the Hospital Board and Local Board (as those terms are defined in the Application) for management of QAPI at Waterbury Hospital post-closing.	Testimony of Von Crockett
5. The financial feasibility of the proposal.	Testimony of Jonathan Spees and Steven Aleman

Topic	Prefile Testimony
6. How prices for, and the cost of, health care services at Waterbury Hospital will be affected by PMH's acquisition.	Testimony of Mitchell Lew, M.D. and Jonathan Spees
7. The charity care policies to be implemented at Waterbury Hospital following the transfer of ownership and how they compare to PMH's current charity care policies.	Testimony of Jonathan Spees
8. The commitment PMH is willing to make to performing future health needs assessments for the communities in GWHN's service area in a manner that allows for widespread public input, collaboration with other health care providers in the community as well public dissemination of the assessments and Waterbury's implementation plan to address the identified needs.	Testimony of Von Crockett and Jonathan Spees
9. The expected timing of the creation of the Independent Foundation, its basis for 501(c)(3) status, and the timing and content of the approximation actions for those charitable funds restricted as to use and those funds whose unrestricted income can and will be used to pay off GWHN liabilities post close.	Testimony of James Moylan and Carl Contadini

At your request, one (1) hard copy and (1) electronic copy have been provided to each Office. If you have any questions or need anything further, please feel free to contact Ann Zucker at (203) 252-2652 or Michele Volpe at (203) 777-6995. Thank you for your assistance in this matter.

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Very truly yours,

Carmody Torrance Sandak & Hennessey LLP

By: _____
Ann H. Zucker
Its Partner

Bershtein Volpe & McKeon, P.C.

By: _____
Michele Volpe
Its Partner

cc. Kimberly Martone, Director of Operations, Department of Public Health
Division of Office of Health Care Access
Jonathan Spees, Prospect Medical Holdings, Inc. (via regular mail)
Darlene Stromstad, Greater Waterbury Health Network, Inc. (via regular mail)

PREFILE TESTIMONY OF
CARL CONTADINI

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

April 26, 2016

Attorney General Docket No. 15-486-02
OHCA Docket No.: 15-32017-486
Greater Waterbury Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc.

Testimony of Mr. Carl Contadini, Chair of the Board, The Waterbury Hospital and Greater Waterbury Health Network, Inc.

Good Afternoon, Attorney Zinn-Rowthorn and Hearing Officer Hansted. On behalf of all members of the Greater Waterbury community, I welcome both the members of the office of the Attorney General and the representatives of The Office of Health Care Access to our community.

I thank you for the time that you have again invested in a careful examination of a proposed acquisition of Greater Waterbury Health Network, Inc., this time by Prospect Medical Holdings Inc. ("Prospect"). We appreciate the care and patience with which you and your staff have approached this matter.

We have presented you with thousands of pages of supporting documentation describing a transaction that we are convinced presents the best opportunity to preserve Waterbury Hospital and to both continue and enhance health care services in our community on a going-forward basis. The Hospital Board and management spent countless hours weighing the Hospital's challenges and options in deciding upon Prospect in this transaction. I am joined today by several other witnesses who will speak to our efforts along with attorneys, bankers and other advisors who have assisted us in this process and who will be available to respond to any particular questions you may have.

I've served on the hospital board since 2005; I am firmly convinced of two things: our Board exercised the requisite diligence with respect to this transaction and that having Prospect in our community will ensure continued access to high quality medical care.

I. Clear public need for and community benefits for the transaction

Over the last ten years, Waterbury Hospital has experienced repeated financial losses because of declining reimbursement, the increasing complexity of health care treatments, poor economic conditions state wide, and in particular in Waterbury. In addition, like most community hospitals

nationwide, national health care reform has presented a difficult challenge for GWHN. It is no longer able to access capital for improvements needed in its infrastructure. Over the same ten years, the Waterbury Hospital has experienced increased demand for emergency and urgent care services and behavioral health care services. Waterbury Hospital is a safety net hospital, serving one of the most economically disadvantaged communities in the State.

Without a financially sound purchaser, healthcare in the Greater Waterbury community will suffer. The financial strength of Prospect, its commitment to favorable charity care policies, and its Coordinated Regional Care model, which has been detailed thoroughly in the Application and Completeness Questions make Prospect the right choice. Our Board firmly believes that the Prospect transaction will ensure that high quality, sustainable health care remains accessible for our community.

I would like to briefly review some of the statutory criteria for your deliberations in this matter and how we addressed each of these in our journey.

II. The Hospital's Due Diligence in Deciding to Transfer, Selecting the Partner and Negotiating the Terms of the Transfer (C.G.S. § 19a-486c (a)(2)(A), (B) and (D))

A. Decision to Transfer

The Board has exercised due diligence in making its election to transfer, selecting the partner and negotiating the terms and conditions of the transaction. In our Application, we described the process by which the Hospital evaluated the issues it faced and the options it had to meet those challenges. Waterbury Hospital has been struggling financially and has explored a number of transactions since 2005. The Board examined numerous alternatives for the Hospital's future. We sought the advice and experience of nationally recognized outside experts. We considered many possibilities including retaining independent status, as well as entering into partnerships and affiliations with other non-profit health systems. After a thorough deliberative process involving review of numerous reports provided to us by expert national consultants including PriceWaterhouse Coopers, Kaufman Hall, and Cain Brothers, we concluded that it was imperative to seek a partnership with an entity that could provide us with access to capital and economies of scale to insure the Hospital's continued high level of quality services.

In 2012, we submitted an application for a joint venture with Saint Mary's Hospital and LHP Hospital Group. The diligence related to that effort was thoroughly explained in that application. After a year of incredibly diligent efforts, LHP terminated the process. Nobody was more disappointed than me. However, our fiduciary obligations brought us back to the table immediately. After another extensive period of due diligence and deliberations, we entered into a Letter of Intent with Vanguard Health Systems, Inc. (later acquired by Tenet Health Corporation ("Tenet"). After a lengthy negotiation, diligence and regulatory process, this transaction, too, was terminated by our potential partner in February of 2015.

We could not, and cannot, permit our community to be without strong sustainable healthcare that provides all medically necessary services right here in Waterbury. GWHN's task force met very quickly after Tenet announced its withdrawal from Connecticut. There were a number of meetings

among Tenet and hospital representatives and government officials aimed at bringing Tenet back to the table but ultimately these were unsuccessful.

The Task Force requested Cain Brothers to re-canvass the market for prospective partners. There was a strong sentiment that the Tenet decision had made Connecticut unappealing for for-profit entities and, in fact, informal outreach efforts revealed this to be the case. In addition to for-profit systems, there were some exploratory conversations with two academic medical centers, but ultimately no paths forward were identified with these centers.

B. Selection of Purchaser

As to our due diligence in the selection of a purchaser, the initial RFP process in 2011 was carefully coordinated by our legal advisors and investment banker, Cain Brothers and, as detailed in the Application, was very thorough. Through its work in the prior two transactions with Cain Brothers , the Task Force had become knowledgeable about possible acquirers. As it approached a third transaction GWHN's advisors noted that as first LHP, and then, Tenet, terminated their transactions, the pool of potential acquirers grew smaller and the attractiveness of Connecticut and Waterbury also diminished.

During the first quarter of 2015, the Task Force again met a number of times with its advisors and kept the GWHN Board apprised of its activities. Three out of state for profit candidates contacted Cain Brothers and indicated their interest in Waterbury Hospital; two submitted proposals. After studying these proposals, the Task Force presented the two proposals to the Board. One proposal was from Prospect, which had participated in the processes during the prior two deals. The following factors continued to be important to the Board:

- Continuance of high quality health services in the community
- Local participation in governance
- Economic value, including willingness to deploy capital in Waterbury
- Form of transaction
- Overall strategic plan
- Familiarity with the New England marketplace.

The Board was encouraged by the transaction and regulatory process that Prospect had recently successfully completed in Rhode Island and Prospect's review and understanding of the recent Connecticut regulatory activities.

C. Negotiating Terms of the Transfer

The Board was thorough in developing the transaction structure and successfully negotiated terms and conditions for a transfer that significantly benefits our community. These include Prospect's commitment to invest in needed capital expenditures for the Hospital as well as a local presence on an advisory board. With the help of Cain Brothers, the terms of the Letter of Intent were thoroughly negotiated first among the business people and then the parties' counsel.

During the course of the Transaction, we learned that, 1) it was likely that the Hospital would not have sufficient cash to close the Transaction, and 2) several of Prospect's hospitals were subject to Immediate Jeopardy findings by CMS. These factors required the transaction team to again negotiate to accommodate some unanticipated issues. Each of these issues required extensive diligence and negotiation on the part of our Board and management team, as well as the cooperation and collaboration of the parties to resolve them. You will learn more about our "Quality Assurance Letter" and on the financial accommodations that Prospect has made to facilitate a closing in other documentation submitted and during the hearing.

III. Independent Expert Fairness Evaluation (C.G.S. § 19a-486c(a)(2)(C))

Our conclusions as to the adequacy of the Prospect proposal were validated by a fairness opinion from the firm of Principle Valuation. We initially chose Principle after conducting an RFP process during the proposed transaction with LHP in 2012; Principle also performed the fairness opinion for the proposed transaction with Tenet in 2014. Having performed these evaluations as well as the valuations for Saint Mary's, we believed that they had in-depth knowledge of the Connecticut market. Their opinion found the Prospect proposal to be at a fair market value for the Hospital and transferred affiliates. We have been fortunate in successfully negotiating a transaction value that rewards the local community with a purchase price providing at least fair market value for the assets being transferred.

IV. Conflicts of Interest (C.G.S. § 19a-486c(a)(3))

We engaged in a thorough conflict disclosure effort at GWNH and Hospital board levels. Additionally, we have reviewed potential conflicts of interest for the experts and advisors involved in this process. We disclosed that there are several physicians on our Board that are employed by the Hospital or its affiliates and that one such physician is also on the board of the independent physician association recently formed by Prospect.

V. No Manipulation of Asset Value (C.G.S. § 19a-486c(a)(5))

Related to your consideration of fair market value, there is no evidence that any improper manipulation of GWHN's fair market value has occurred.

VI. Financing Does Not Place the Hospital's Assets as Unreasonable Risk (C.G.S. § 19a-486c(a)(6))

To this end, I would note that Prospect has represented that it does not plan to borrow from a third party to close this transaction.

VII. Management Contracts (C.G.S. § 19a-486c(a)(7))

There is no management contract in the proposed transaction.

VIII. Transfer of Charitable Assets (C.G.S. § 19a-486c(a)(8))

The Hospital recognizes that, as a charitable organization, its assets must be used in a manner consistent with the Hospital's mission and purpose. In the case of assets which have been donated to the Hospital, the intentions of the donors must also be respected and followed. Our Application outlines that a new post conversion foundation will be formed. It will receive charitable assets as enumerated by the Attorney General's office. The entity known as "The Waterbury Hospital" will liquidate the liabilities. A completely separate, independent foundation will be formed to receive those charitable assets that are appropriate for the independent foundation to hold, as well as the net proceeds of the Transaction, if any.

IX. Provision of Adequate Data (C.G.S. § 19a-486c(a)(9))

Finally, I understand that all of the requests of the Office of the Attorney General and Office of Health Care Access received as of today have been satisfied and we will, of course, provide any further information requested.

CONCLUSION

In summary, we believe that the transaction proposed with Prospect not only satisfies all the applicable statutory criteria, but also is a transaction that best addresses the ongoing health care needs of the community while preserving Waterbury Hospital as a functioning health care institution. I thank you for the opportunity to make this presentation to you today and would be happy to address any questions or comments you might have.

* * * *

PREFILE TESTIMONY OF
DARLENE STROMSTAD

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

April 26, 2016

Attorney General Docket No. 15-486-02
OHCA Docket No.: 15-32017-486
Greater Waterbury Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc.

I. Introduction

Good afternoon. My name is Darlene Stromstad and I am the President and Chief Executive Officer of Greater Waterbury Health Network, Inc. ("GWHN"). Thank you for providing us with the opportunity to submit testimony in support of GWHN's proposal to transfer its assets to Prospect Medical Holdings, Inc. ("Prospect").

Mr. Contadini has provided important background on the proposed transaction and has outlined the extensive process that the Board has undertaken in reviewing the transaction. I would like to provide some additional information on the substance of the proposed transaction and how it will meet the important public need for continued access to care in Greater Waterbury.

II. Background

Waterbury Hospital has been committed to providing high quality, compassionate health care to the greater Waterbury community since the 1890s. GWHN and its affiliates and joint venture companies, are economic anchors, particularly in the City of Waterbury where it is one of the biggest employers. The primary goal in entering into the proposed transaction with Prospect is to ensure sustainable local access to a full range of health care services for the greater Waterbury community.

Reduced reimbursement, increased taxes, and increased capital requirements have all combined to put community hospitals in financial jeopardy. GWHN is no different. In fact, on an operating basis, GWHN has often operated at a loss. The Connecticut hospital tax and reductions in state payments to hospitals have exacerbated an already difficult situation. As a nonprofit entity, access to capital markets is limited, and the market for the tax exempt debt of community hospital is nonexistent.

In his prefile testimony, Mr. Contadini outlined the process that GWHN followed to choose Prospect as an affiliation partner. I'd like to highlight some key terms of the transaction and why they satisfy the regulatory requirements for approval by the Office of the Attorney General and Office of Health Care Access.

III. Benefits of Proposed Transaction

The proposed asset purchase agreement and the other details of the transaction are described in the Application and the "completeness questions" and answers. Some key highlights include:

- The consummation of the transaction will permit GWHN to satisfy its outstanding debt.
- Any funds remaining after payment of liabilities and completion of a wind-down of operations will be transferred to an independent tax exempt foundation which will ensure that the funds will continue to be used in furtherance of charitable health care purposes and to support and promote health care generally in the communities traditionally served by GWHN.
- The hospital will have a local advisory board that will oversee quality issues and permit continued community involvement in operations.
- Prospect will offer employment to all employees of GWHN in good standing and assume GWHN's pension obligations to employees. Existing union contracts will be maintained.
- Subject to the conditions described in the Application and Asset Purchase Agreement, Prospect will commit to spend not less than $55,000,000 on capital items at GWHN over seven years.
- After the closing, Prospect will continue GWHN's policies regarding charity care or will adopt other policies that are at least as favorable to the community as GWHN's current policies.

Prospect will bring the strength of its Coordinated Regional Care model (described in more detail in Prospect's testimony) to the service area of GWHN and provide innovation that GWHN could not possibly provide independently. This model will provide opportunities for collaboration among hospitals, physicians and other providers in the region in new value-based purchasing programs offered by payors. From a resource perspective, Prospect's capital commitments and better access to the capital markets will ensure ongoing investment in hospital operations. In addition, the ability to participate with Prospect's other hospitals in group purchasing will create economies of scale. Access to capital, retirement of GWHN's current debt, and pension liabilities assured, will better position the post-closing hospital financially going forward. In simple terms, Prospect's financial strength and health care experience will ensure continued access to care at a local level with the backing of a national health system.

IV. Public Need and Satisfaction of Regulatory Requirements for Approval

Mr. Contadini has described the due diligence to determine the feasibility to enter into the proposed transaction with Prospect, and to ensure that charitable assets are preserved as required by the Conversion Act (C.G.S §19a-486 et seq.). In addition, as detailed in our application, the proposed transaction satisfies the requirements for approval by the Office of Health Care Access as set forth in C.G.S. §19a-486d and C.G.S. §19a-639. A brief summary is set forth below:

A. The Purchaser Has Made a Commitment to Provide Health Care to the Uninsured and the Underinsured (C.G.S. §19a-486d(a)(1)).

As set forth above, Prospect has agreed to ensure that the post-closing hospital will maintain and adhere to GWHN's current policies regarding charity and indigent care or adopt other policies that are at least as favorable to the community as GWHN's current policies. Health care for the uninsured and underinsured in our community will continue and access to care for our neediest populations will be preserved.

B. Health Care Providers or Insurers Will Not Be Offered the Opportunity to Invest or Own an Interest in the Purchase or Entity Related to the Purchaser (C.G.S. §19a-486d(a)2)).

No health care provider or insurer will be offered the opportunity to invest or own an interest in Prospect or any Prospect affiliate as part of this transaction.

C. The Proposed Transaction is Consistent With Applicable Policies and Standards adopted in Regulations by the Department of Public Health (C.G.S. §19a-639(a)(1)).

The Office of Health Care Access has not yet completed the regulations. However, it has adopted various procedural standards (Connecticut Agencies Regulations §§19a-613-1 through 19a-653-4) and has issued an informational Certificate of Need Application Guide. The Applicants have responded to all requests for information and have worked to ensure that all procedural requirements have been fulfilled.

D. The Proposed Transaction is Consistent with the Overall Goals of the Statewide Health Care Facilities and Service Plan (C.G.S. §19a-639(a)(2)).

The Office of Health Care Access first published its Statewide Health Care Facilities and Services Plan (the "Plan") in October 2012 and supplemented it in 2014. Section 1.4 of the Guiding Principle of the Plan states: "The goal of [the Office of Health Care Access]'s planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources, and provide financial stability and cost containment of health care services." The Plan specifically acknowledges that hospital merges, affiliation and acquisitions are anticipated as a response to major changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5)

The proposed affiliation with Prospect will enable GWHN to benefit from economies of scale when purchasing supplies and services, share best practices, and improve access to capital. This will allow GWHN to make capital investments and reinvestment in its facilities, equipment, and in medical and information technology. These investments will in turn allow GWHN to attract and retain physicians and providers needed to serve its communities. All of this will ensure continued access to primary care, acute care and post-acute care in the communities currently served by GWHN and, as such, is consistent with the overall goals of the Statewide Health Care Facilities and Service Plan.

E. There is a Clear Public Need for the Proposed Transaction ((C.G.S. §19a-639(a)(3)).

Waterbury Hospital is a "safety net" hospital. It serves a critical role in the community's health care. In 2015:

- 12,000 individuals were treated at Waterbury Hospital as inpatients;
- 180,000 individuals were treated on an outpatient basis;
- 134,000 patient visits to community-based physicians employed by Alliance Medical Group and Cardiology Associates of Greater Waterbury ;
- Almost 2,300 patients were cared for at home by the VNA;
- 150,000 patients were treated at Access Rehab Centers; and
- The emergency department treated 54,000 patients, including a large number of patients in need of urgent behavioral health services.

It is clear from the statistics that GWHN serves a critical need in the community. The proposed transaction will ensure that this need continues to be met and that services remain available in the local community.

F. The Proposed Transaction is Financially Feasible (C.G.S. §19a-639(a)(4)).

The Proposed Transaction will result in a stronger and more financially secure GWHN. The purchase price to be paid by Prospect will permit GWHN to pay its debts, including its outstanding bonds. Prospect will also assume GWHN's pension liabilities. This, combined with economies of scale and purchasing power as part of a broader network, will better position GWHN to handle the new regulatory and financial reality for community hospitals today.

In addition, Prospect's capital commitments will permit significant capital improvements over the next several years to the infrastructure of the hospital. Further, implementation of Prospect's Coordinated Regional Care model will offer GWHN facilities access to resources, systems and efficiencies

which are essential for long term success in the evolving health care marketplace.

As Prospect will testify in more detail, Prospect is financially stable and prepared to commit to continued care in the GWHN community.

G. The Proposed Transaction Will Improve Quality, Accessibility and Cost Effectiveness of Health Care Delivery to the Region, Including for Medicaid Recipients and Indigent Persons (C.G.S. §19a-639(a)(5)).

As detailed in the application, the proposed transaction will ensure continued access to care for the residents of Greater Waterbury. Through implementation of its innovative Coordinated Regional Care model, quality care will be maintained in a cost-effective manner and GWHN will be poised to participate in newly evolving reimbursement models. And because Prospect has committed to continued charity care and to continue participation in Medicaid, Medicaid recipients and indigent persons will be assured of access to needed services.

H. GWHN's and Prospect's Past and Proposed Provision of Health Care Services to Relevant Patient Populations, Including Medicaid Recipients and Indigent Persons Support Approval of the Transaction (C.G.S. §19a-639(a)(6)).

Prospect has committed to maintain services for Medicaid recipients and to charity care policies for uninsured and underinsured patients at least as favorable as those currently in place at GWHN. Patient access for all will be maintained and there is no anticipated change in the payor mix as a result of the proposed transaction.

I. GWHN and Prospect Have Satisfactorily Identified the Population to be Served by the Proposed Project and Satisfactorily Demonstrated that the Identified Population has a need for the Proposed Service (C.G.S. §19a-639(a)(7)) and Have Established Sufficient Utilization Statistics (C.G.S. §19a-639(a)(8)).

In the application, GWHN and Prospect have identified the population to be served and submitted volume statistics establishing that GWHN serves a significant number of patients each year. Approval of the proposed transaction will ensure that these services remain available to the community.

J. GWHN and Prospect Have Satisfactorily Demonstrated that the Proposed Transaction Will Not Result in an Unnecessary Duplication of Existing or Approved Health Care Services or Facilities (C.G.S. §19a-639(a)(9)).

The proposed transaction will preserve existing services and will not establish unnecessary duplication. At this time, no additional services or facilities are planned.

K. The Proposed Transaction Will Not Reduce Access to Services by Medicaid Recipients or Indigent Persons (C.G.S. §19a-639(a)(10)).

As referenced above, there are no proposed changes to the current payor mix as a result of this proposed transaction. Services to Medicaid recipients and to indigent persons will be maintained. Charity care will be available on the same, or more favorable, terms as they are currently.

L. The Proposed Transaction Will Not Negatively Impact the Diversity of Health Care Providers and Patient Choice in the Geographic Region (C.G.S. §19a-639(a)(11)).

The proposed transaction will not negatively impact the diversity of health care providers and patient choice in Greater Waterbury. Prospect does not currently have operations in Connecticut, so the addition of Prospect to the market will enhance diversity and patient choice.

M. Consolidation Resulting from the Proposal Will Not Adversely Affect Health Care Costs or Accessibility to Care (C.G.S. §19a-639(a)(12).

The proposed transaction will not result in any new consolidation, but will preserve current services. As Prospect implements its Coordinated Regional Care model, patient care will be better coordinated and provided in a cost-efficient manner.

As summarized above and as described in significant detail in the application, the applicable regulatory requirements have been satisfied and we urge the agencies to permit the proposed transaction to proceed.[1]

V. Conclusion

Our Board has carefully considered the future of GWHN and believes the reasons to join another system are clear. This affiliation with Prospect will provide needed capital and expertise to allow GWHN to adapt to new health care models of care. Most importantly, it will ensure access to critical health care services to all who reside in Greater Waterbury, including the uninsured and underinsured.

* * * *

[1] Because the application in this proceeding was filed before December 1, 2015, the provisions of subsections (d) and (e) of C.G.S. §19a-639 are not applicable, and are not, therefore, addressed here.

PREFILE TESTIMONY OF
CARL SHERTER, M.D.

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

April 26, 2016

Attorney General Docket No. 15-486-02
OHCA Docket No.: 15-32017-486
Greater Waterbury Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc.

PREFILE TESTIMONY OF CARL B. SHERTER, M.D.

My name is Carl B. Sherter and I am the immediate past Chief of Staff of The Waterbury Hospital. I've been a practicing physician for over 40 years as a Pulmonary & Critical Care Physician at both Waterbury Hospital and Saint Mary's Hospital for most of that time. During the last 13 years, I've also served as the chair of the State of Connecticut's Medicaid Pharmacy & Therapeutics Committee; this is a volunteer position. This committee has saved the State of Connecticut tens of millions of dollars and still provided the most liberal list of medications to Medicaid patients. As a practicing physician and a volunteer on this committee, I see the deep health care needs of our community.

I also serve as a member of the Hospital's Board of Trustees and its finance committee. Since its inception in 2011, I have served on the Transaction Task Force that was charged with examining the Hospital's opportunities with various capital partners. Health care has changed dramatically since I began practicing and even over the five years that we've been looking for a capital partner, there have been significant changes. Under the Affordable Care Act, health care systems will strive to keep patients healthy and avoid hospitalization. This will require a robust system of care, a data driven system with ancillary services that provide the best care available to every patient. Every health care system is starting to build this model. Our chosen partner, Prospect Health, has this system in place and has proven success with this system in multiple states. We will be up and running in months, not years.

Part of my due diligence was to visit the two hospital system in Rhode Island that Prospect acquired about a year ago. We met with their board President, their CEO, their Chief Nursing Officer and 6 physicians who practice in this system. One physician was in private practice, the others were employed. We spent several hours with this group and asked many

questions. They said the best way to sum up the experience was that Prospect was "real and delivered all they promised". They were practicing accountable care medicine within months and it is working. Patients are happy and get much better care than in the old way of practicing medicine. In Rhode Island, Prospect is eagerly taking on Medicaid patients. Hundreds of physicians signed on over the first year. They like the new model Prospect offers.

This venture will be good for the City of Waterbury. Our population is older then most other Connecticut cities. The poverty rate is over 20%. Our unemployment is over 12%. This venture will help stabilize our city, as the hospitals and the City are the three largest employers.

Waterbury Hospital has provided excellent health care to this community. I am proud of the over 1000 physicians we have trained, many still in our area. We have medical students from all three Connecticut medical schools. I am proud of the nurses, certified aides, respiratory therapists, physician assistants and pharmacists that we have trained. I am proud of the staff of the Hospital for earning numerous awards for quality health care, in spite of the hospital's financial constraints.

Prospect has met numerous times with the physicians who practice in Waterbury. They have reached out to every physician group and attended the Staff Executive Meeting to report on progress and answer questions. The physicians have asked every question and gotten straight forward answers. They support this venture. Over 300 Waterbury physicians have already signed up for Prospect's IPA (Independent Physician Association). This demonstrates their support.

After almost 40 years of practice at Waterbury Hospital, I have seen the Hospital struggle as a stand-alone hospital. We have an average physicians' age of over 59 years. It is getting increasingly difficult to bring young healthcare workers to Waterbury. They want to see a secure future for their practice. They want up to date modern equipment to diagnose and treat their patients. They want a stable future with a capital partner that will help with the economy of scale. They know that the health care delivery model has changed. They want to hit the field running with the proven model that Prospect offers.

The people of Waterbury want excellent health care in their own city. They are a community of family values and support one another. Most of my patients come to my office with family members. They all ask me "Is it going to happen?" I answer "We all hope so". We need a capital partner to make this happen, and Prospect is an excellent choice.

Respectfully submitted,

Carl B. Sherter, M.D.

PREFILE TESTIMONY OF
JAMES MOYLAN

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

April 26, 2016

Attorney General Docket No. 15-486-02
OHCA Docket No.: 15-32017-486
Greater Waterbury Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc.

Good Afternoon, I'm James Moylan, the interim Chief Financial Officer of Greater Waterbury Health Network, Inc. (GWHN") and I have worked closely with our President, Darlene Stromstad, our Board Chair, Carl Contadini, and our bankers, Cain Brothers, in the development of the process and structure for resolving GWHN's post closing liabilities and the development of an independent foundation for the net proceeds and certain charitable funds.

In accordance with Connecticut's Conversion Statute, an independent foundation ("Independent Foundation") will be created to receive certain charitable funds and, the net proceeds, if any, of the proposed transaction. An Application for Exemption (Form 1023) will be filed about the time of the closing of the Transaction or shortly thereafter; it will seek recognition as a "Type 1 supporting organization" "public charity". The purposes and drafts of Independent Foundation's constituent documents have been detailed at pages 0041-0043 and 00924-00937, respectively. The transfer of any funds to the Independent Foundation would occur after the receipt of a favorable determination letter from the Internal Revenue Service, and, in the case of funds subject to an approximation or construction action, after a judgment has entered and any appeal period has expired.

Unrestricted Charitable Funds:

After all the liabilities of The Waterbury Hospital are satisfied and it is dissolved, an approximation action or construction action, as the case may be, will be required with respect to the unrestricted funds held by the Hospital and the unrestricted income received by the Hospital from trusts held by third parties. These actions regarding the unrestricted assets will determine whether the Independent Foundation will receive the assets and/or income after the Hospital's dissolution or if the assets or income will be paid over to others after the Hospital's dissolution, in order to satisfy the intent and directions of the original donors.

The charitable funds that fall within this category are the following:

- *Unrestricted Income Funds held by The Waterbury Hospital*: Brooker, Forester, Hallden
- *Unrestricted Income Funds held by Third Parties*: Elton, Fulton, Frank Keeling, Jacob Keeling, Lamb, Peck, Poole, W. Easton Smith
- *Unrestricted Income Funds held by Third Parties – with Gift Over Provisions*: Dayton, C. Hellman, R. Hellman, Kirk

Restricted Charitable Funds:

An approximation action will also be required with respect to all the restricted funds (including bed funds) held by the Hospital in order to determine whether the Independent Foundation will receive those assets and/or income or whether the assets or income will be paid over to others, in order to satisfy the intent and directions of the original donors. GWHN anticipates filing the approximation action as to the restricted funds with the Connecticut Superior Court promptly after the receipt of a favorable determination letter from the Internal Revenue Service for the Independent Foundation. The approximation action would involve several gifts which, in light of the sale of GWHN's assets, will no longer be able to achieve their expressly stated purpose. In this action, GWHN will seek a determination that these funds should be transferred to the Independent Foundation so that they can continue to serve their desired charitable purposes as closely as possible to the original charitable intent of the donor. The restricted charitable funds that would be the subject of such actions are:

• Anderson 1943 and 1986 Funds • At Risk Kids • Bevans • Blakesley • Chase [used to underwrite the Henry S. Chase Outpatient Center "Chase Clinic"] • Crozier • Fulling • Grad Nurse • Junior League • Sarann B. Kazanjian Memorial Fund [medical and surgical equipment] and Student Nurse Scholarship Fund	• Kingsbury [bed fund] • Mayo • Meigs • Merriman [defray expenses of personnel of Clinical and Pathological Laboratories to attend scientific meetings] • Permanent Bed Fund [bed fund] • Flora S. Page and George W. Smith [bed fund] • Sperry [bed fund] • Stoughton • Various Gifts [bed fund]

Certain restricted bed funds are in effect hybrids. They allow excess income over that paid out for the specific beneficiaries (for ex. the residents of Naugatuck as to the Hopkins and Warner Funds) to be used for the General Uses and Purposes of the Hospital. The Hospital intends to use such excess income to pay liabilities after the closing of the proposed transaction. After the liabilities of the Hospital are satisfied and it is dissolved, an approximation action or construction action, as the case may be, will be required with respect to these funds

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

* * * *

PREFILE TESTIMONY OF VON CROCKETT

DEPARTMENT OF PUBLIC HEALTH	:	**DOCKET NO. 15-32017-486**
OFFICE OF HEALTH CARE ACCESS	:	
	:	
OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-02**
	:	
IN RE: GREATER WATERBURY HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**April 26, 2016**

PRE-FILED TESTIMONY OF VON CROCKETT

I. Introduction

My name is Von Crockett and I am the Senior Vice President of Corporate Development at Prospect Medical Holdings, Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") regarding the proposed acquisition of assets of Greater Waterbury Health Network, Inc. ("GWHN"), including The Waterbury Hospital ("Waterbury Hospital"), by PMH. Specifically, I will address how PMH's operational resources and industry know-how will benefit GWHN.

Professional Background

Prior to my appointment as Senior Vice President of Corporate Development at PMH, I served as the Chief Executive Officer of Southern California Hospital at Culver City from 2009 to 2012. Prior to joining Southern California Hospital at Culver City, I held various positions in the health care industry including, but not limited to, President and Chief Executive Officer of Centinela Hospital Medical Center in Los Angeles, California; System Chief Operating Officer of Centinela Freeman Health System in Los Angeles, California; Chief Operating Officer and then the Chief Executive Officer for Doctors Medical Center San Pablo/Pinole in San Pablo, California;

Chief Financial Officer of Sutter Healthcare in Antioch, California; and Chief Financial Officer of Sharp Chula Vista Medical Center in San Diego, California.

Summary of PMH's Operations

PMH owns and operates fourteen (14) acute care and behavioral hospitals around the country in various markets. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 300,000 patients in Southern California, South Central Texas and Rhode Island through a network of primary care physicians and specialists.

My remarks today will address how PMH's operational resources and strengths are beneficial to GWHN and support the approval of the Application through PMH's (i) quality assurance and performance improvement, (ii) successful track record with healthcare operations; (iii) ability to achieve operational efficiencies; (iv) collaboration with the local board on community insight and needs ("Local Board"); and (v) allocation of resources for building comprehensive networks of care.

II. Quality Assurance and Performance Improvement

PMH is dedicated to providing quality care and is continually aiming to improve quality and performance. PMH strives for the best patient outcomes while maintaining high standards of patient safety. PMH recently modified its Quality Assurance and Performance Improvement (QAPI) oversight over its network of hospitals. Historically, PMH relied on local management and the local advisory boards to provide reports and make requests for resources as necessary with respect to each hospital's QAPI. More recently, PMH hired the following positions at a corporate level:

A. Chief Quality Officer;

B. Associate Vice President of Regulatory and Patient Safety.

Additionally, the following roles are in the process of being filled:

C. East Region VP of Quality and Patient Safety

D. Corporate AVP of Regulation and Accreditation Programs

E. Corporate Director of Performance Improvement

F. Directors of Survey Readiness Teams:

i. Clinical Practices

ii. Environment of Care and Life Safety

iii. In Patient Care

The roles of these new officers ("Corporate Quality Team") are to interact with local board and local leadership on continuous basis to ensure safety, adherence to regulatory requirements, clinical excellence and patient satisfaction at all PMH hospitals and to closely monitor execution of plans of correction in response to any issue raised in surveys by regulatory authorities responsible for quality. It will also be the responsibility of the Corporate Quality Team and their staffs to identify issues early and communicate them to PMH corporate so that we may address such issues quickly and efficiently. Accordingly, it will be the responsibility of the Corporate Quality Team to marshal corporate resources to address all of the above areas. The collective duties of the Corporate Quality Team are to:

1. Monitor the activity and quality programs at each hospital (including all adopted recommendations by the local advisory boards);
2. Assist in providing necessary resources to implement all quality programs at local hospitals;

3. Assist in providing necessary resources to address corrective action plans in the event that quality goals are not met by the local hospitals;
4. Assist in accreditation survey readiness; and
5. Assist in sharing of best practices among all local hospitals.

The description of the Corporate Quality Program, including an organizational chart, is described in more detail in Exhibit A to my testimony. The CVs of the persons hired for the positions are attached as Exhibit B to my testimony.

At the local level, direct responsibility for the quality programs for each PMH hospital is administered by hospital leadership so that any and all quality issues raised by physicians and/or staff are timely addressed and quickly resolved. Oversight of the local leadership is provided by, and is the responsibility of, PMH's senior management.

The increase in corporate oversight over QAPI resulted from recent surveys at PMH's California hospitals that resulted in Immediate Jeopardy status at two of its hospitals. At Los Angeles Community Hospital, an Immediate Jeopardy status citation was issued by CMS due to physician misconduct. A corrective action plan was submitted and a re-survey was conducted that resulted in the hospital remaining out of compliance for two areas: Nursing Services and Infection Control. A corrective action plan for these two deficiencies has been submitted to CMS and the hospital is awaiting a re-survey for these two deficiencies.

At Southern California Hospital at Culver City, two Immediate Jeopardy citations were issued on account of (i) temperature and humidity issues primarily in the operating rooms; and (ii) sterilization of surgical products. Corrective action plans were submitted and PMH had a resurvey by CMS the week of April 4th, 2016 and is awaiting the written results of the re-survey.

OHCA and the AG are in receipt of the Corrective Action Plan for Los Angeles Community Hospital (Responding to Deficiencies Cited as a result of Resurvey Conducted February 16-17, 2016) submitted by PMH.

In response to the Immediate Jeopardy citations, PMH has taken swift action, including but not limited to, increasing its oversight of QAPI at its network of hospitals, as well as retaining a nationally recognized consulting firm to conduct a review of the operations and all policies and procedures in California. Based on the recommendations of the consulting firm, PMH has implemented a number of changes in the policies and procedures as well as the operations of its Southern California Hospitals. The Quality Improvement Plan adopted at Los Angeles Community Hospital and Southern California Hospital at Culver City has been provided hereto as Exhibit C.

PMH has agreed to maintain the respective quality program and goals of Waterbury Hospital for a period following the transaction. PMH is also committed to provide the necessary staff to support such quality programs. Finally, PMH agrees to share the best practices at its other facilities with Waterbury Hospital.

III. PMH Has a Successful Track Record

PMH has measureable success in all of its acquired hospitals. PMH has a successful track record operating fourteen (14) hospitals in different states for close to a decade. Many of these facilities were financially distressed when acquired by PMH. PMH has never abandoned or closed a hospital that it has purchased. PMH's management team has years of experience in operating community hospitals. PMH even purchased a closed hospital in California and re-opened it. PMH's hospital operations were established in August 2007 with the acquisition of Alta Hospitals System, LLC, a system of four community-based hospitals in Southern California with a combined

339 licensed beds. PMH's experience and know-how in operating hospitals, especially hospitals with financial distress at acquisition, will benefit the GWHN community.

In addition to its operational expertise with hospitals, PMH has thirty (30) years' experience operating and supporting independent physician practice associations (IPAs) under risk-based arrangements with payors in California. PMH has successfully engaged insurers and developed partnerships that result in a full range of risk contracts. PMH manages the provision of healthcare services to approximately 260,000 members through its network of over 8,900 primary care physicians and specialists. Its hospitals manage the care of 30,000 capitated Medicaid beneficiaries. This experience allows PMH to bring its process knowledge and experience to build and operate health systems to Connecticut.

PMH has been successful in implementing its Coordinated Regional Care ("CRC") model at all of its hospitals. Successful implementation of CRC has brought coordination of care across its hospitals and all providers in its network and is a key to PMH's operational success. My colleague, Dr. Lew, will speak to the specific elements and the achievements of CRC.

PMH has been successful in embracing health care reform measures. PMH is on the forefront of health care reform measures and has the operational resources to integrate such measures into health systems. To align with health care reform, PMH and its affiliated medical groups and hospitals collaborate closely in partnership with health plans to give patients and their families highly coordinated, personalized care. PMH's experience in embracing health care reform will provide the post-transaction health system the ability to adjust to a rapidly changing healthcare delivery environment and improve care coordination.

PMH's know-how derived from its past and current operational success in health care systems and hospitals across the country will benefit the GWHN community and ensure the sustainability of the health system in the service area.

IV. PMH Will Bring Beneficial Operational Efficiencies to GWHN

PMH will bring valuable operational efficiencies to the post-transaction health system. PMH hospitals benefit from PMH's years of experience in hospital ownership and PMH's economies of scale. Affiliation with PMH will offer GWHN economies of scale that include: (i) purchasing power, (ii) supply chain benefits, (iii) employee benefits savings, and (iv) streamlined revenue collection, among other value added initiatives that will reduce the cost of operations. As with all of its hospitals and affiliated entities, PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. The cost savings to operations will improve finances and help ensure the sustainability of the post-transaction health system well into the future.

Through PMH's economies of scale, the hospitals will enjoy higher discounts for supplies and drugs as part of a larger organization in the first year. Subsequently, the hospitals will be entitled to discounts and pricing through better compliance with purchasing protocols. It should be noted that by affiliating with a larger organization, the post-transaction health system will benefit from economies of scale due to PMH's overall purchasing power. The post-transaction health system will realize benefits in lower supply costs, drug costs and costs related to consultants.

Additionally, costs to provide fringe benefits will decrease in the first full year of operation because PMH is essentially self-insured for providing benefits. Self-insured benefits save on the profit portion of the premium generally paid to third parties in order to provide fringe benefits to

employees. Furthermore, the operational resources of PMH will be made available to develop and implement strategic plans. Also, revenue collection will be streamlined through PMH's system.

PMH has realized numerous efficiencies at all its hospitals. Examples include the elimination of rental expenses of beds, pumps, ventilators and other equipment by purchasing the items, reduced registry use through proper hiring and management of registry utilization process, development of staffing matrix for all Southern California hospitals and implementation of real-time monitoring of labor standard adherence. PMH has leveraged surgical volumes and practice standardization to reduce implant pricing. PMH has also implemented pharmacy cost reduction strategies such as auto-substitutions and Group Purchase Organization pricing at all hospitals. PMH will bring operational efficiencies to the GWHN system that result in cost savings.

In today's health care landscape, PMH's operational efficiencies are critical to meeting the requirements of health care reform measures. PMH's operational efficiencies are necessary to improving the financial viability of GWHN to ensure the sustainability of the post-transaction health system.

V. PMH's Utilization of a Local Board

PMH's operational strategy for GWHN includes the use of a Local Board to achieve provider and community insight into health system operations and community needs. Following the closing, Waterbury Hospital will maintain a Local Board made up of nine (9) to twelve (12) members. It is PMH's preference that at least one-third of the Local Board members are physicians and it is expected that GWHN Board members will serve on the Local Board. The CEO of the post-closing hospital will be a member of the Local Board. A more detailed description of the Local Board is found in the Asset Purchase Agreement. The Local Board will advise on community needs and serve as a resource to PMH with respect to the investment of capital,

assisting with maintenance and implementation of a strategic business plan for the hospitals, making recommendations for medical staff credentialing and quality assurance programs as well as assisting with issues relating to accreditation for the hospitals.

Use of a Local Board results in a delivery model which engages the local community and strengthens the health system, and provider and community alignment. PMH's commitment to including these local advisors into operational discussions ensures that the community values are understood and the community needs are recognized.

VI. PMH's Operational Resources Will Aid in Building Comprehensive Networks of Care

PMH's operational resources, including the proprietary CRC model, will benefit the post-transaction health system by aiding in the integration and expansion of the post-transaction health system's network of providers, as well as its program offerings beyond what can be done by GWHN alone. PMH's operational strategy, as implemented through CRC and other measures, has led to stronger integration with provider affiliates to coordinate care. It has also improved the overall health of the population and enhanced the standard of care for its patients. PMH will implement these operational resources in the GWHN health system.

First, PMH utilizes its operational resources and CRC model to build regional networks with its hospitals and medical groups that contribute to the entire continuum of care. Collaboration with PMH, though the implementation of its CRC model, provides an environment that aligns GWHN's physicians and other providers across the continuum of care, provides access to evidence-based practices to improve quality and patient safety, enhances efficiency through uniform productivity and financial management, and develops integrated information systems. PMH focuses on the management of patients with challenging chronic medical conditions in order

to keep patients well in the most appropriate care setting. By utilizing appropriate care settings and resources and managing chronic care patients, PMH avoids unnecessary, inefficient and duplicative services and reduces medical errors which result in improved quality, efficiency and cost savings. My colleague, Dr. Lew, will discuss the CRC model in more depth and the results it has achieved within PMH operated health systems.

Further, the PMH approach to care coordination through the pursuit of delegated risk-based contracts aligns incentives across all healthcare stakeholders. Through collaboration with healthcare payors, PMH is able to further integrate care delivery among providers and regionalize the health care delivery system in the service area. PMH is also better equipped to more effectively identify patients at risk and build upon existing initiatives. PMH's experience in obtaining these risk-based contracts will benefit the post-transaction health system and provide new incentives for care coordination.

Lastly, PMH has developed and implemented high intensity care management programs that integrate behavioral and physical health capabilities to effectively manage the care of patients with significant co-morbidities in all of its hospitals. PMH will bring this capability to the GWHN system along with other resources to meet health care reform requirements. PMH is committed to succeed in new value-based performance delivery model and has the ability to share best practices among its member hospitals to reduce readmissions. In addition, PMH will work with the medical staff of the hospitals on clinical quality matters to share best practices and establish clinical quality goals and measure progress.

In sum, PMH's operational resources will be beneficial to the post-transaction health system because it will develop regionalized coordinated care systems, enter into risk-based

contracts that promote cost effective quality care and integrate PMH's high intensity care management programs.

VII. Conclusion

PMH's vast operational experience, resources and strategies will greatly benefit the post-transaction health system beyond what GWHN can do today. PMH's successful track record, its ability to achieve operational efficiencies, the use of Local Boards to serve as a resource for community insight, and PMH's ability to build comprehensive networks of care are all examples of PMH's valued added operational expertise. Without experienced operational resources, hospitals cannot meet the increasing burdens required to be competitive in today's healthcare environment. PMH has the strategic and operational ability that will directly benefit GWHN and the community it serves. For all of the foregoing reasons, we respectfully request that the Attorney General and the Department of Public Health division of the Office of Healthcare Access approve this Application.

Thank you for your time and I welcome any questions.

EXHIBIT "A" TO VON CROCKETT TESTIMONY

Introduction

Philosophy: To ensure that our patients receive the right care, at the right time, in the right setting, with efficiency and compassion.

Mission: Above all, we are committed to quality in all aspects of healthcare delivery, including:

- Striving for the best possible patient outcomes
- Maintaining the highest standards of patient safety
- Acting with integrity at all times
- Promoting open communication
- Collaborating to better serve the healthcare needs of our communities

Purpose: The PMH Quality and Patient Safety Program will focus on continuous enhancement of quality and safety for all we serve. Every employee plays a crucial role in ensuring patient, visitor and employee safety. We will work to reconnect quality and patient safety to clinical care thereby promoting high quality, safe, effective and efficient care. Additionally, the program will strive to build a just culture of safety by implementing strategies to reduce medical errors. Reducing risk and ensuring safety requires increased attention to systems that prevent and mitigate errors. The corporate quality and patient safety team will work with hospital to provide appropriate solutions to ensure best practices, resulting in quality patient care and service.

Goal: Build corporate and regional structures and processes necessary to become a high reliability organization promoting patient-focused, high quality, safe, compassionate, efficient, and effective care.

Model: We will achieve our mission and purpose through building and sustaining a robust quality and patient safety program at all levels of the organization. The key elements of this program will include: innovation, service, education, transparency, patient and physician partnerships. We will be using the Donabedian Quality of Care Model as our framework for building the program. Our initial focus will be on creating the corporate structure to enhance our ability to build processes and achieve outcomes.

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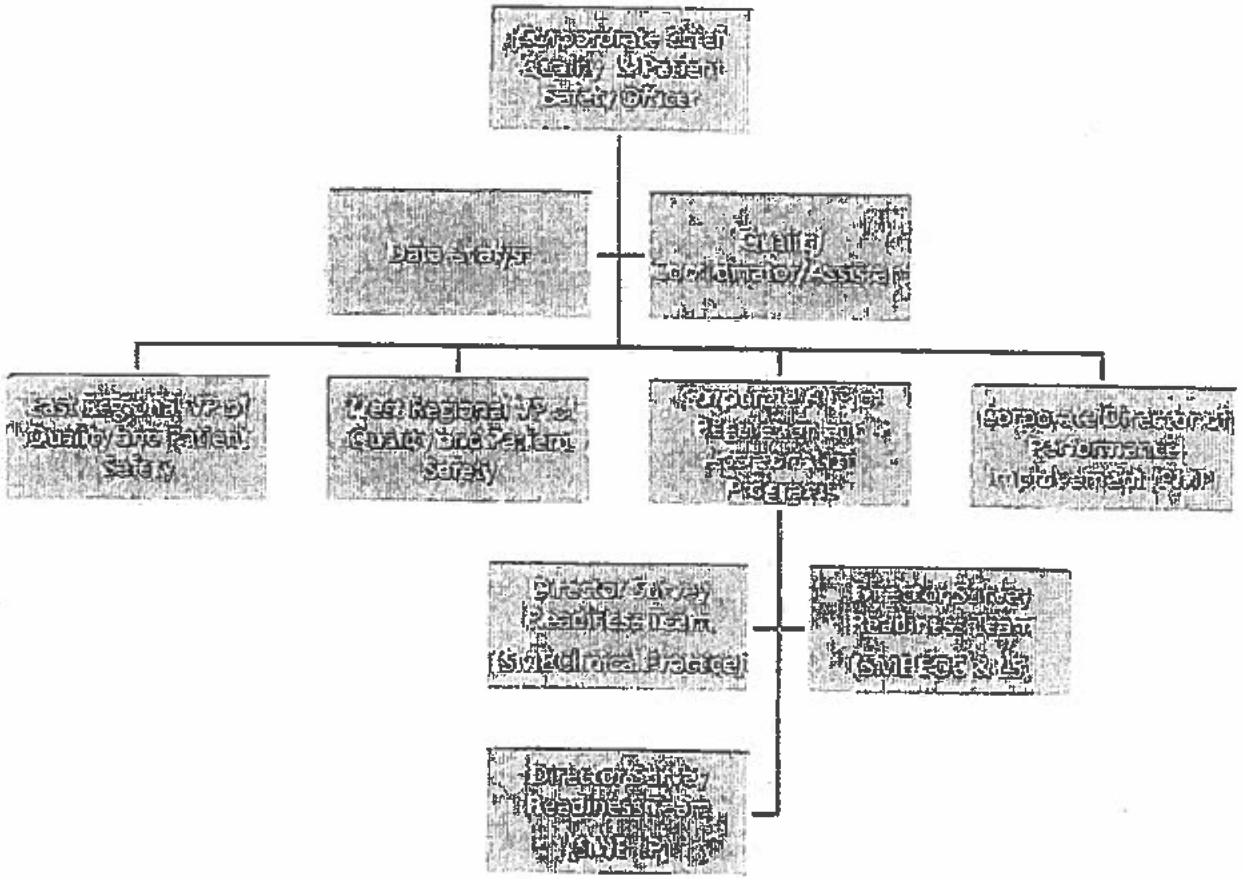
Structure

Corporate and Regional Quality Department Structure



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Roles and Responsibilities

Chief Quality Officer - Provides Oversight to the Corporate Quality and Patient Safety Agenda. Activities may include but are not limited to:

- Collaborates with hospital executives, and engages with hospital leaders and clinicians in identifying and implementing unique and varied initiatives aimed at improving patient care quality and safety
- Leads continuous improvement programs throughout the organization and helps develop a culture of continuous improvement and excellence
- Collaborates with hospital executives and engages with leaders and clinicians throughout the organization to build quality, efficiency, effectiveness and a sense of shared accountability
- Collaborates with hospital executives and engages with leaders to ensure continuous survey readiness.
- Takes a clinical leadership role in evaluating care delivery and develops the infrastructure for improvement
- Strengthens the data and information capabilities of the organization and champions a data-driven environment

Regional VP of Quality and Patient Safety – Reports to the CQO.

- Provides regional support and expertise to hospital leadership
- Leads continuous improvement programs in the assigned region and helps develop a culture of continuous improvement and excellence in those regions
- Reviews all regional hospital serious events and assists the hospital leadership in mitigation as appropriate.
- Collaborates with regional hospital executives and engages with leaders and clinicians throughout the organization to build quality, efficiency, effectiveness and a sense of shared accountability
- Collaborates with hospital executives and engages with leaders to ensure continuous survey readiness and sustainment of performance improvement activities
- Strengthens the data and information capabilities at the regional level and champions a data-driven environment

01543

Corporate AVP Regulation and Accreditation – Reports to the CQO

- Provides oversight to all aspects of the Survey Readiness program
- Serves as subject matter expert and hospital resource for regulation and accreditation programs
- Creates, implements, and maintains survey readiness tools that meet federal, state, and local statutes and regulations.
- Ensures survey readiness tools meet the applicable accreditation standards i.e. TJC, DNV, etc.
- Deploys and provides oversight to the survey readiness team during hospital site visits.
- Reviews all survey action plans and provides constructive input prior to submission to the appropriate regulatory or accreditation agency.

Director Survey Readiness Team – Reports to AVP of Regulatory and Accreditation Programs

- Serves as a subject matter expert and support person to all hospitals.
- Completes full survey readiness assessments at hospitals and provides recommendations for improvement
- Tracks hospital performance improvement activities based on site visit findings

Director of Performance Improvement – Reports to CQO

- Leads and facilitates system and hospital wide strategic quality and safety improvement projects.
- Develops and coaches performance improvement implementation strategies in support of the strategic goals.
- Collaborates with hospital executives, and engages with hospital leaders and clinicians in designing and implementing quality, patient safety and clinical excellence performance improvement activities.
- Leverages complex decision support/data systems to establish operation and quality related metrics to measure progress and sustainability of improvement efforts/initiatives.
- Ensures seamless hand-off of completed improvement initiatives to hospital operations leadership
- Engages with hospital leadership in implementing special initiatives to support the high reliability performance improvement initiatives of PMH as required.

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Data Analyst - Reports to CQO

- Interprets data, analyzes results using statistical techniques and provides ongoing quality, patient safety, and clinical effectiveness reports
- Develops and implements data collection systems and other strategies that optimize statistical efficiency and data quality
- Works closely with management to prioritize business and information needs
- Locates and defines new process improvement opportunities
- Prepares tables, charts and graphs to summarize the results of these analyses

Quality Coordinator/Assistant – Reports to CQO

- Serves as Administrative Assistant to the Corporate Quality and Patient Safety program
- Assists with gathering quality and patient safety data for analysis

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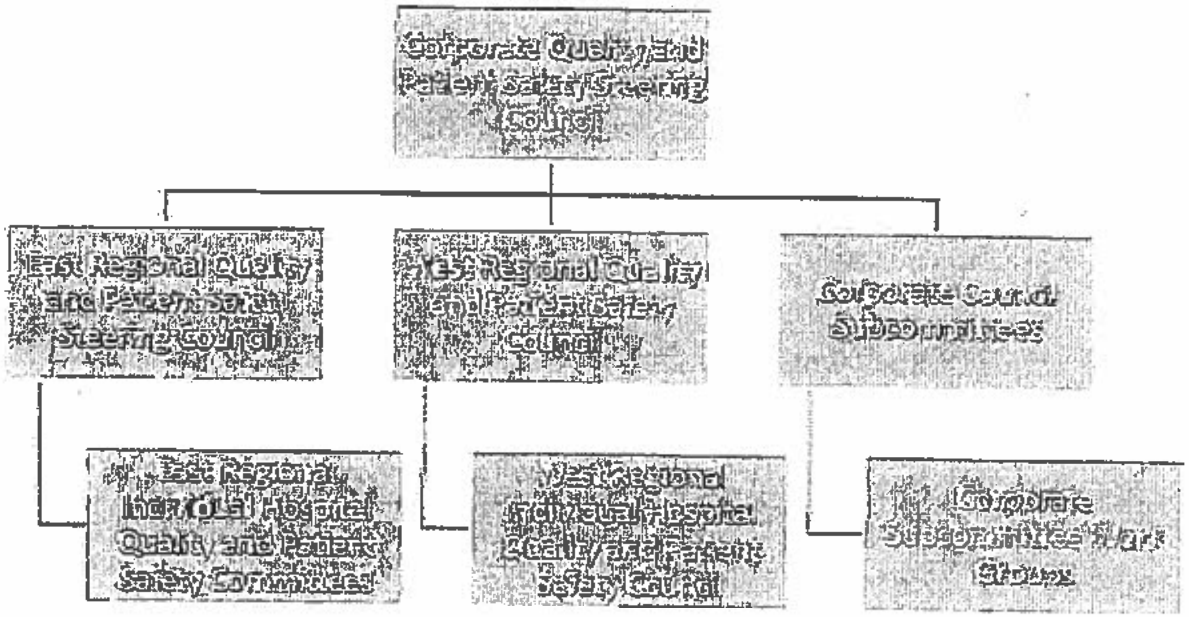
Quality and Patient Safety Communication and Reporting Structure



Note: Hospital Quality and Patient Safety Committees will report up through the appropriate regional steering council which will then report up through the corporate Quality and Patient Safety Steering Council.

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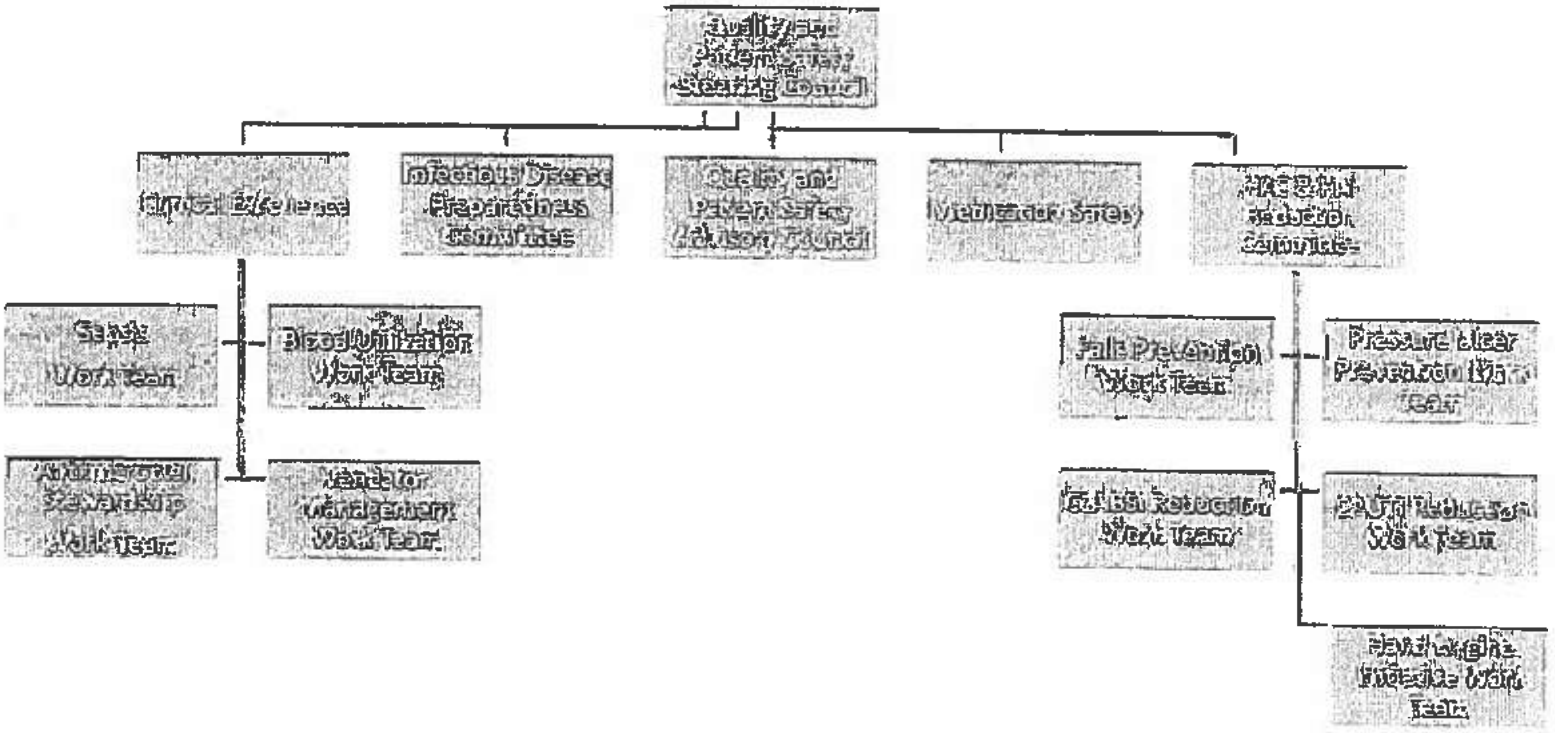
Corporate Quality and Patient Safety Steering Council Subcommittee and Work Group Sample Structure



Note: The above diagram outlines potential subcommittees and work groups. The actual infrastructure will be dependent upon the identified needs at the hospital, regional and corporate levels.

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Corporate Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the regional councils
- Assists with the development of the corporate quality and patient safety strategy
- Prioritizes Quality and Patient Safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from chartered committees and work teams
- Engages in identifying ongoing quality and patient safety performance improvement opportunities.
- Ensures follow-up on regional initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety.
- Assist with barrier removal to achieve quality and patient safety strategies.

Regional Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the hospital councils
- Assists with the development of the corporate and regional quality and patient safety strategy
- Prioritizes regional quality and patient safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from regional chartered committees and work teams
- Engages in identifying ongoing quality and patient safety performance improvement opportunities for the region.
- Ensures follow-up on hospital initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety at the regional level.
- Assist with barrier removal to achieve quality and patient safety strategies.

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Corporate Steering Council Chair: PMH Chief Quality Officer

Suggested Members: Appropriate Corporate Senior Leadership, Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, Medical Staff Director, IT&S Director, Supply Chain, others

Regional Steering Council Chair: TBA

Suggested Members: Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, IT&S Director, Supply Chain,

Ad Hoc Members: Radiology, Lab, Medical Staff, others as appropriate to subject matter

Committees: Responsible for building the infrastructure and provide input for key quality and patient safety activities. Potential Committees may include Medication Safety, Clinical Safety Improvement, Infectious Disease Preparedness, Regulation and Accreditation, Clinical Excellence, others as needed.

Rapid Action Work Groups: Completes rapid work for quick process and outcome improvement as needed. Examples include Core Measure improvement, HAC prevention, HAI prevention, Clinical Excellence etc. The team is responsible for creating and initiating performance improvement programs to include project plan, key elements, tool kits etc. Teams have a limited life depending upon the work product and outcomes.

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Process

High Reliability Organization: A high reliability organization is an organization able to continually manages their environment thoughtfully and assume a constant state of vigilance resulting in the fewest possible number of errors, despite operating in a high stress, high-risk environment. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations. These changes will be achieved through:

- Leadership's commitment to achieving zero patient harm
- A fully functional just culture of safety throughout the organization
- Widespread deployment of highly effective process improvement tools

PMH is in the process of adopting high reliability behaviors and strategies to ensure a reduction in overall medical errors for our patients. High reliability organizations are built on a foundation of a just culture of safety. A key component of building this foundation is a robust incident reporting and analysis system to better understand trends, opportunities and strengths. We encourage that every unsafe condition, near miss/great save or harm event be reported and analyzed to identify opportunity for improvement to prevent future harm. We commit to maintaining transparency through sharing best practices and lessons learned across all of our hospitals. We further commit to build and share evidence-based, best practice, and performance improvement processes and tools kits to assist with supporting our quality and patient safety high reliability organization initiatives.

Strategies:

- **Accreditation and Regulation Readiness** – Implement an accreditation and regulation survey readiness team to ensure all hospitals are continually in compliance with the highest level of quality care and patient safety standards as defined by CMS, TJC, DNV, NCQA, and applicable State and local statutes and regulations. Provide subject matter expertise and tools to support the facilities in ongoing survey readiness.
- **Patient Experience** – Create and implement a patient experience program to ensure that each patient is treated with respect, compassion, consideration and is an integral partner in his or her plan of care.

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- **Quality Measurement and Process Evaluation** – Build a standardized corporate quality and patient safety dashboard with national benchmarks. Institute monthly Quality and Patient Safety calls to review metrics, analysis and action plans to ensure ongoing improvement.
- **Patient Safety Improvement** – Create and implement a plan to move all hospitals towards a just culture of safety and accountability. Ensure quality and safe delivery of healthcare by defining and promoting consistent processes for identifying situations that may put patients or others at risk and acting to prevent or control those risks i.e. thorough and credible analysis of incidents of harm, near misses/great catches; FMEAs; ongoing learning through transparency, and implementation of patient safety tools.
- **Quality Improvement** - Maximize pay-for-performance for quality performance and outcomes metrics including VBP, readmission reduction program, HAC/HAI reduction program, Medicare spending per beneficiary (MSPB), Meaningful Use etc.
- **Technology Integration** – Maximize available patient safety technologies including CPOE, health information technology, clinical decision support, bar coding and other technologies to enhance the quality and patient safety strategy.
- **Clinical Excellence** – Improve mortality, complications, and length of stay through implementation of clinical excellence initiatives such as sepsis, stroke and STEMI management; effective blood utilization; ventilator management; and antibiotic stewardship.
- **High Reliability Organization** – Implement proven high reliability techniques and nationally recognized best practices to prevent harm and promote quality of care such as Red Rules (limited), SBAR (Situation, Background, Assessment and Recommendation), and STAR (Stop, Think, Act and Review) etc.

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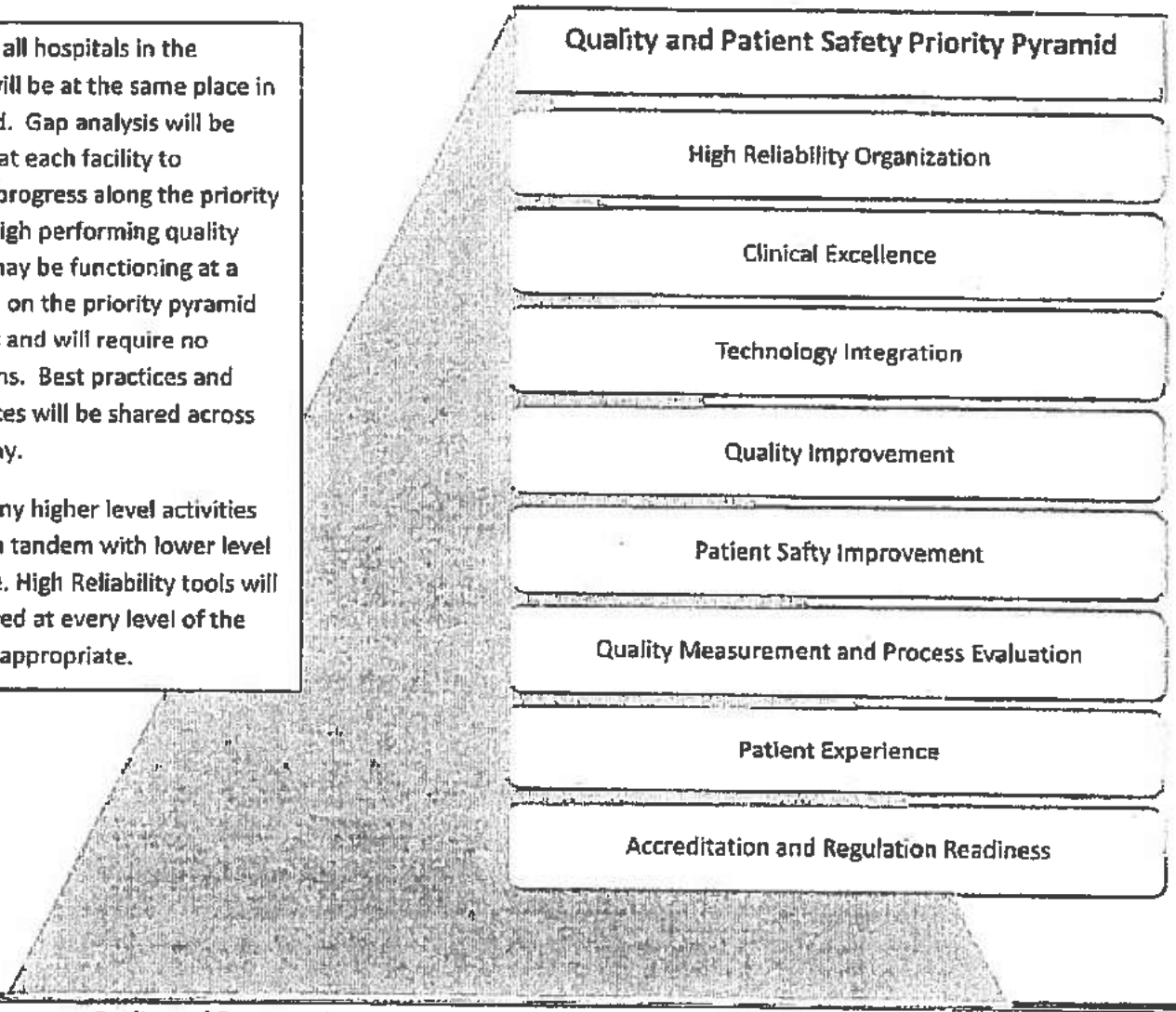
Note I: Not all hospitals in the Company will be at the same place in the pyramid. Gap analysis will be completed at each facility to determine progress along the priority pyramid. High performing quality programs may be functioning at a higher level on the priority pyramid than others and will require no interventions. Best practices and performances will be shared across the company.

Note II: Many higher level activities will occur in tandem with lower level activities i.e. High Reliability tools will be introduced at every level of the pyramid as appropriate.



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Outcomes

Corporate Quality and Patient Safety Dashboard

Quality, clinical and patient safety performance and outcomes will be measured via the newly created corporate Quality and Patient Safety Dashboard. Dashboards will be share across the company for the purpose of benchmarking and learning from other.

Hospital Quality and Patient Safety Call

Outliers will be addressed during the regularly scheduled hospital quality and patient safety calls. Best practices will be identified and shared with other hospitals in the company during these calls. The hospital will implement performance improvement activities to address the root cause and followed-up will occur during the next call. Once well established, the hospital call will occur at the regional level with a summary report forwarded to the corporate CQO.

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EXHIBIT "B" TO VON CROCKETT TESTIMONY

DEBBIE BERRY, RN, MSN, LHRM, CPHQ, CPPS, CWCN, CCN

[redacted]

PROFESSIONAL EXPERIENCE

4/2015 – Present

Vice President of Quality and Patient Safety
Gulf Coast Division (GCD) of HCA, Houston, TX

- Work directly under the GCD Chief Medical Officer to provide oversight for clinical operations and excellence; quality assurance; performance improvement; patient safety, risk prevention and management; infection prevention and control; and medical staff operations for a 13 hospital division.
- Collaborate with the DCMO to build structure and processes to drive improvement in quality, patient safety and clinical excellence outcomes for the GCD by creating and co-chairing a Quality and Patient Safety Steering Council with subcommittees on Medication Safety, Infectious Disease Preparedness, CVAT, Hospital Acquired Conditions/Infection Prevention, and Clinical Excellence.
- Collaborated with the DCMO to build the quality and patient safety strategic plan for 2016 – 2018 that will maximize Value Based Purchasing and other pay-for-performance opportunities; as well as, lead to improved clinical and quality outcomes.
- Provide oversight for Quality and Clinical Operations data mining and analysis for division and facility opportunities.
- Developed and implemented performance improvement strategies and tactics leading to a 25% reduction in catheter associated urinary tract infections, 30% decrease in time to pain management for long bone fractures and a 32% improvement in Outpatient Stroke measures.
- Designed and implemented a Leapfrog "Getting to A" initiative that led to a division average score of "C" to a division average score of "B" and includes a division-wide IRR and validation process.
- Collaborate with the CMO and Performance Improvement team to drive an 11% improvement in sepsis mortality through improving sepsis bundle

compliance by 60%, an 11% improvement in blood utilization, and sustained improvements in 4 of 5 Cardiovascular PCI indicators.

4/2013 - 8/2015 **Assistant Vice President of Quality and Clinical Operations**
West Florida Division (WFD) of HCA, TAMPA, FL

- Work directly under the WFD VP of Quality and Clinical Operations to provide oversight for clinical operations and excellence; quality assurance; performance improvement; patient safety, risk prevention and management; infection prevention and control; and medical staff operations for a 16 hospital division.
- Provide oversight for many of the day to day operations of the Quality and Clinical Operations Department
- Provide oversight to all regulatory and accreditation activities in the 16 hospitals in the WFD of HCA.
- Created a Sentinel Event Webinar preparation program that has led to 100% acceptance of plans of correction and successful completion of measures of success for the past four years.
- Completed due diligence from a quality, patient safety, infection prevention, nursing operations and medical staff perspective for 4 hospitals under consideration for acquisition.
- Provided on-site facilitation for 5 newly acquired facilities to successfully transition to corporate standards and achieve 100% Joint Commission and CMS accreditations within 120 days of acquisition.
- Responsible for successful credentialing and privileging of 100% of the Medical Staff in new WFD facilities.
- Created a multilevel tracking system that enables a 30 day transition of Medical Staff from a closing facility to the closest HCA facility.
- Co-designed and implemented performance improvement "Key Elements" strategies leading to a 60% reduction in hospital acquired conditions in 4 years.
- Participated in the design of the WFD centralized claims management process.
- Co-designed and implemented a Core Measures Playbook II with gap analysis and tool kit leading to 13 of 16 WFD hospitals awarded Top Performers on Key Quality Indicators© by the Joint Commission for 2013.
- Assumed the Severe Sepsis project management in March 2012 leading to a decrease mortality rate from 42% to 32% and ALOS from 12 days to 9.5 days.
- Co-designed a Dependent Healthcare Provider Scope of Service and evaluation program which has been adopted by HCA Corporate.
- Created and provide oversight for the Quality and Patient Safety Leadership Orientation Program.

- Provide oversight for Quality and Clinical Operations data analysis and data presentation.

2/2011 – 4/2013 **Director of Regulatory and Accreditation Programs**
West Florida Division of HCA, Tampa, FL

- Worked directly under the WFD VP of Quality and Clinical Operations; serves as the Division expert on regulation, accreditation, clinical practice and risk prevention and management.
- Provided oversight to all regulatory and accreditation activities in the 16 hospitals in the WFD of HCA.
- Designed a QRS follow-up program for continuous survey readiness which has led to a decrease in TJC RFIs in the WFD.
- Co-designed a TJC Sentinel Event webinar process which has led to 100% acceptance of WFD hospital action plans and attainment of 100% Measures of Success within the required 4 months.
- Co-designed and implemented performance improvement "Key Elements" strategies leading to a 60% reduction in hospital acquired conditions and never events.
- Co-designed and implemented a Core Measures Playbook leading to 12 of 15 WFD hospitals awarded Top Performers on Key Quality Indicators© by the Joint Commission for 2012.
- Assumed the Severe Sepsis project management in March 2012 leading to a decrease mortality rate from 42% to 35% and ALOS from 12 days to 11 days in one year.

8/2009 – 2/2011 **Vice President of Quality, Risk Management and Infection Control**
Northside Hospital, HCA St. Petersburg, FL

- Provided oversight of all Quality, Performance Improvement, Risk Management, and Infection Control activities for Northside Hospital.
- During tenure significantly improved all Core Measures to the 90th percentile and increased HCAHPS composite score by 4%.
- Redesigned Medical Staff peer review, ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) program leading to improved oversight of physician and LIP practice.
- Achieved 90% measure of success compliance in 6 months on all QRS identified opportunities from May 2010 QRS survey.
- Facilitated all Root Cause Analysis and Failure Mode Effects Analysis activities and ensured 100% compliance with designed plans of correction.

- Responsible for presentation and facilitation of analysis of quality and performance improvement data in the Quality and Patient Safety Committee, Medical Executive Committee and Board of Trustees.

10/2007 – 6/2009 **Assistant Vice President of Clinical Practice**
Washington Adventist Hospital, Takoma Park, MD

- Provided clinical operation oversight for ED, Critical Care, Medical-Surgical, Telemetry, Women's Services, Surgical Services, and Pharmacy Services.
- Assumed the Interim Chief Nurse Executive role during the 6 month search process.
- Provided leadership for Case Management, Hospitalist Program, and Intensivist Program – decreased hospital LOS by 4% despite a 10% increase in Case Mix Index
- Facilitated the design, implementation and monitoring of a new Neurovascular Surgical Service Line and Stroke Program.
- Designed and implemented the Professional Practice Education Program (PPEP) and other professional practice programs led to a 20% increase in recruitment and retention of nurses
- Redesigned and provided oversight to the Montgomery County Latino Health Care Initiative Nurse-in-Training Program – wrote and was awarded a $259,000 NSPI grant to support the management of the program for four years.
- Improved customer satisfaction scores by 15 % in key clinical areas
- Assisted in a Pharmacy redesign program leading to a 55% decrease in medication errors reaching the bedside.
- Facilitated the design and implemented a Rapid Medical Evaluation process in the ED which decreased patients leaving without treatment by 30% in the first three months.

5/2005 – 10/2007 **Internal Consultant/Corporate Manager, Resource Management and Performance Improvement Department**
MedStar Health, Lutherville, MD (Seven hospital Healthcare System)

- MedStar Visiting Nurses Association (VNA) Error Reduction Project
- Decreased service batch errors by 50% in 6 months
- Decreased Medicare Revenue held by fatal billing errors from $2,687,806 to $1,248,860 in 6 months.

- Served as a clinical consultant to Corporate Supply Chain. Designed a 3- year corporate bed fleet replacement program leading to $400,000 in contract savings.
- Facilitator for System-wide Performance Improvement Task Forces that all led to decrease in mortality, morbidity, LOS and 30-day readmission rates including initiatives in Surviving Sepsis Campaign, pressure ulcer prevention, glycemic control, heart failure, and culture of safety.
- Redesign Projects leading to improved efficiency, improved revenue capture, decrease in length of stay and decreased wait times and improved customer satisfaction
    - Franklin Square Hospital Center– Preadmission Testing
    - Georgetown University Hospital – Case Management Department, Wound Center and Ankle and Foot Center
    - Good Samaritan Hospital – Heart Care Unit and Patient Flow Initiative.

10/1999 – 5/2005 **Clinical Nurse and Case Management Specialist, Medicine Service Line**
Franklin Square Hospital, MedStar Health, Baltimore, MD

- Served as a clinical consultant to Corporate Supply Chain. Designed a 3- year corporate bed fleet replacement program leading to $400,000 in contract savings.
- Partnered with physicians to design and implement protocols, guidelines and outcomes measurement for multiple disease entities.
- Provided supervision for all educators and clinical specialists in the Medicine Service Line.
- Planned, implemented and sustained multiple evidence-based, performance improvement programs across the Medicine Service Line.
- Designed and implemented care coordination rounds on all units resulting in a 10% decrease in length of stay.
- Implemented the DRG Assurance Program maximizing coding for complexity of care leading to a 20% increase in CMI in one year.
- Achievements:
    - Delmarva Medicare Excellence Award for three areas of responsibility: CHF, MI, and Pneumonia
    - Solucient 100 recognition for Heart Failure, MI and Pneumonia
    - Achieved recognition in US News & World Report Top 100 Hospitals for cardiology and endocrinology.

4/1998 – **Clinical Liaison Nurse, Corporate Materials Management**

10/1999 *MedStar Health, Baltimore, MD*

- Served as clinical expert and liaison for all corporate contracts
- Served as medical and OR product consensus builder leading to over $1.5 million in systems savings in 18 months.
- Coordinated all new product implementations across the system.

3/1985 – 4/1998 **Nurse Director/Nurse Educator/Staff Nurse/Home Care Case Manager**
Church Hospital, MedStar Health, Baltimore, MD

- Provided Critical Care, Home Care and Medical-Surgical clinical practice, management and education
- Served as member and chairperson on multiple quality, patient safety and performance improvement committees.

9/1988 – 5/2009 **Adjunct Faculty Villa Julie College and Community College of Baltimore County**
Baltimore, MD

10/1981 – 3/1985 **Cardiac Rehabilitation Nurse/ICU Staff Nurse**
Greater Baltimore Medical Center, Baltimore, MD

6/1980 – 10/1981 **Telemetry Nurse**
Wheeling Hospital, Wheeling, WV

EDUCATION

2015 –	Doctoral Student in Nursing Practice	*Capella University, Minneapolis, MN*
2003 – 2005	Masters of Science in Nursing	*University of Phoenix, Phoenix, AZ*
1985 – 1987	Masters of Science in Instructional Technology	*Towson University, Towson, MD*
1976 – 1980	Bachelors of Science in Nursing	*Wheeling Jesuit College, Wheeling, WV*

LICENSES AND CERTIFICATIONS

- Licensed Registered Nurse (RN) Florida and Texas
- Licensed Healthcare Risk Manager (LHRM) Florida
- Certified Professional in Health Care Quality (CPHQ)
- Certified Professional in Patient Safety (CPPS)

- Certified Wound Care (CWCN)
- Certified Continence Nurse (CCN)

PUBLICATIONS

Author/Co-Author

- Hospital Readmission Prevention in Lippincott's Nursing Advisor (2015 in publication). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Core Measures in Lippincott's Nursing Advisor (2015, 2016). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Unethical Practices: Recognizing and Reporting in Lippincott's Nursing Advisor (2014). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott's CE Module - Mandatory Education, Hospital: National Patient Safety Goals (2013). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott's Nursing Advisor Core Measure Content Set for AMI and Heart Failure (2013). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Bahner, J, Berry, D, & Hooker, J. Nursing Leadership for Safety (Section XIV, Chapter 5) in Patient Safety in Emergency Medicine (2008), Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.

Contributor/Reviewer

- Sentinel Events in Lippincott's Nursing Advisor (2015). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott Nursing Procedures & Skills (2010, 2011, 2012, 2013, & 2014 versions). Wolters Kluwer/ Lippincott, Williams & Wilkens.
- Lippincott Patient Safety Program: Communication Among Caregivers and Restraints (2013). Wolters Kluwer/ Lippincott, Williams & Wilkens.
- Preceptor Preparation Program: Web based interactive e-learning course (2012). Wolters Kluwer/ Lippincott, Williams & Wilkens.

AWARDS, HONORS and Professional Activities

- Member of the National Advisory Board for Strayer University RN to BSN program
- Subject matter expert for quality, patient safety and risk management for Rasmussen University
- Subject matter expert for Core Measures for Lippincott, Williams and Wilkins publishing company.
- Alpha Sigma Nu (National Jesuit Honor Society)

- Sigma Theta Tau (International Nursing Honor Society)
- 2003 Nurse of the Year in a Clinical Support Role, Franklin Square Hospital
- 2004 Excellence in Care Coordination Leadership Award, Franklin Square Hospital

PRESENTATIONS

- **2012 FAHQ Annual Conference:** *Sustained Zero HAPU: Northside Hospital's Journey*
- **2007 SAWC Conference Poster Presentation:** *The design and early implementation of pressure ulcer prevention strategies in a large health care system*
- **2007 MedStar Surviving Sepsis Initiative featured in Maryland Patient Safety Center and MHEI Director of Process Improvement Projects**
- **2005 Care Science National Conference:** *Using Risk Adjusted Data to Evaluate Performance and Drive Change*
- **2005 Delmarva Courage to Improve Conference:** *Establishing Core Measure Compliance*

Thedosia L. Munford, MBA, MS, BSN, RN, NEA-BC

[redacted]

SUMMARY OF QUALIFICATION: Thirty years of diversified acute health care experience and accomplishments in positions of progressive managerial and executive responsibilities. Extensive involvement in organization redesign, renovation and restructuring; cost reduction; fiscal management; human resource management and development; project management; organizational transition; organization preparation for ANCC magnet designation and direction of clinical departments. Accomplishments include:

- Development and implementation of patient focus delivery systems
- Clinical lead for inpatient and outpatient units, ED renovations and construction
- Participated in building of new bed tower
- Facilitated throughput teams to expedite patient flow and decrease LOS by 16%
- Increased Emergency Department (NPS) patient satisfaction in an inner city hospital by 41%
- Decreased RN vacancy rate by 22%
- Exceeded goal for pressure ulcer rate by 44%
- Eliminated use of restraints in medical/surgical units and exceeded goal for decrease use in critical care by 69%
- Other quality matrix accomplishments included meeting and exceeding goals for hand washing, pneumococcal vaccine and influenza vaccine
- Achievement of TJC accreditation and licensure
- Implementation of management development program
- Labor management/union negotiations
- Patient care unit construction redesign for patient-centered care, and patient flow
- Preparation and management of annual budget in excess of $44 million
- Decreased use on incremental overtime by 60%
- Decreased use of external agency nurses by 50%
- Achieved productivity standards for staffing
- Organization development and change management
- Work redesign
- Reduced OR room turnover time down to <30 minutes

PROFESSIONAL EXPERIENCE AND ACHIEVEMENTS

HealthLinx Transitional Leadership 2014-2015

A division of HealthLinx Executive Search, Inc. a healthcare-exclusive consulting and search firm specializing in i) leadership assessment, project management and consulting; ii) the identification and recruitment of permanent management and executive healthcare candidates; and iii) the placement, assistance, and management of transitional leaders.

- **Transitional Leader** -December 2014-April 2015
  Interim Director Professional Practice and Nursing Development (December 2014-April 2015)
  Mount Carmel East Hospital, Columbus Ohio
- As a transitional leader, deliverables included i) validate the recently developed on-boarding plan and provide opportunity for improvement with particular focus on new graduate nurses, medical/surgical, critical care and Emergency Department nurses; ii) assess Clinical Education Department, resource allocation, clinical education staff competency and staff competency assessment model for the Hospital; and iii) assess Shared Governance Model with particular

focus on practice council, support structure and current functioning. Selected accomplishments included,

Ascension Health System **2006-2013**

A national healthcare provider in more than 1400 locations in 29 states and District of Columbia rooted in the loving ministry of Jesus as healer and is committed to serving all persons with special attention to those who are poor and vulnerable.

- **Senior Vice President Patient Care Services/CNO (2010-2013)**
  Providence Hospital, Washington DC
  A 408 bed teaching hospital with ADC of 200 inpatients and 40 behavioral health inpatients, offering medical graduate teaching and serving as a rotational site for domestic and international nursing students. Located in northeast District of Columbia with an average of 45,000 ED visits annually. Other specialties include Diabetes, Certified Stroke Center, Bariatric Services and Wellness Programs, Cardiology, Orthopedics, Sleep Wellness and Geriatric Medicine. As SVP/CNO, reported to president/CEO. Responsibilities included management of total operating budget of >$47 million, staff of >600 FTEs, re-design of throughput processes for main hospital portals (IP and OP surgery, and ED), implemented mid-level leadership development and performance standards for accountability. Selected accomplishments included:
    - decreased RN vacancy rate from >9% to 7%
    - decreased LOS from >5 to 4.2 days
    - eliminated use of agency RNs by 50%
    - decreased ED patient throughput by 30%
    - increased ED patient satisfaction from 32% to 54%

- **Vice President, Inpatient Services (2006-2010)**
  Saint Agnes Hospital, Baltimore, Maryland
  A 296 bed full service teaching hospital with residency program and student nurse rotation serving the greater Baltimore area, located in southwest Baltimore serving diverse communities, with ED visits >82,000. Clinical areas of specialties include Cancer Care, Metabolic, Cardiovascular, Women's & Children's Health, Orthopedic & Spine, Plastic & Reconstructive Surgeries, Stroke, Chest Pain Emergency Program. As VP, reported to senior vice president/CNE. Responsibilities included management of inpatient medical/surgical and critical care units, Nursing Operations (House Supervisors, staff float pool, Nursing Office), Care Management, Nursing Education and Development, management of operating budget of >$25 million, and staff of >200 FTEs, and nursing shared decision making and professional development programs. Selected accomplishments included;
    - decreased LOS from 4.49FYTD July 2008 to 3.95 FYTD May 2010
    - developed and implemented RN Professional Clinical Ladder Program
    - facilitated implementation of nursing leadership academy
    - facilitated strategies in preparation of ANCC magnet designation
    - facilitated nursing clinical research with the first NRB approved nursing research study

Senior Director of Nursing **2003-2006**

Mercy Medical Center, Baltimore, Maryland

A 299 bed teaching ANCC Magnet Designated Hospital located in downtown Baltimore with ED visits >62,000 annually. Clinical specialties include Cancer Care, Diabetic & Endocrine, Gastroenterology & GI Surgeries, Geriatrics, Gynecology, Nephrology, Orthopedic and Pulmonology. As senior director, reported senior vice president/CNE. Responsibilities included management of inpatient medical/surgical units, inpatient substance abuse unit, and OP Chemotherapy, management of operating budget of >$10 million and staff of >250 FTEs. Selected accomplishments included:

- developed nursing management and leadership structure of responsibility and accountability
- managed and lead managers through radical change of re-structuring of responsibilities and accountability
- lead coordination, development and implementation of RN clinical ladder for professional practice
- served as interim VP Patient Care Services
- began nursing and organizational preparation for magnet designation

Director, Patient Care Service **1996-2003**
MedStar Harbor Hospital, Baltimore, Maryland
A 179 bed community focused hospital located in south Baltimore on Patapsco River with an average of 40,000 ED visits annually. Clinical specialties include Internal Medicine, Orthopedic, Oncology, Sports Medicine, Back & Spine, and Women's Service. Mission is to provide a quality, caring experience for patients, communities and those who serve with a patient centered care philosophy. As director, reported to vice president/CNO. Responsibilities included management of inpatient medical/surgical units, critical care and Women's Health. Selected accomplishments included:

- facilitated transition from traditional patient care delivery to patient centered care model
- clinically designed, planned and implemented several patient centered care units with external construction team
- chaired Human Resource Design work team for MedStar transition for recruitment, selection, orientation and retention
- co-chaired work re-design team for Hospital-wide patient flow from admission to discharge

ADDITIONAL EXPERIENCES:

- **Vice President, Patient Care Service** **1993-1995**
  Greater Southeast Community Hospital, Washington DC
  A 400 bed acute care community hospital located in southeast Washington DC serving Prince George's County Maryland communities and southeast Washington DC. As vice president reported to president/CEO. Responsible for all nursing services with select accomplishments that included
  -implementation of position control system
  -expansion of home health services which increased visits by 20%
  -reduced management positions by 40%

- **Assistant Executive Director** **1991-1993**
  Howard University Hospital, Washington DC
  A comprehensive and academic teaching hospital located on campus of Howard University in District of Columbia. Level I Trauma Center with average of 60,000 ED visits annually, performing kidney and liver transplants. As assistant executive director, reported to COO and responsible for all nursing services and nurse management team member for labor contract negotiations.

EDUCATION AND DEVELOPMENT

- Class of 2010 *The Leadership Program of the Greater Baltimore Corporate*
- MBA, University of Baltimore, Baltimore Maryland
- MS Human Development, Howard University, Washington DC
- BSN, Howard University, Washington DC
- Diploma in Nursing, Freedmen's Hospital School of Nursing, Washington DC

LICENSURE AND CERTIFICATION

- RN, District of Columbia #R29886
- RN, Maryland #R128737

- RN, Ohio #RN412755
- NEA-BC #2009013543

CANDICE PETERS, R.N., B.S., MS

EXPERIENCE

KINDRED HEALTH CARE – HOSPITAL DIVISION – WEST REGION – WESTMINSTER, CA.
SENIOR DIRECTOR CLINICAL OPERATIONS (FEB 2009 – CURRENT)
Kindred is an acute long-term hospital caring for catastrophically ill and medically complex patients. Direct Oversight of 7-13 hospitals providing long term acute care (LTAC) in California. Ensured The Joint Commission accreditation for all assigned hospitals; assisted operations support, Quality and Regulator Review (Joint Commission and CMS survey preparation). In 2014 ensured 7 hospitals that were reviewed were re-accredited Joint Commission. Ensured 2 hospitals (2013 and 2015) achieved first time JC Accreditation. Assisted two hospitals successfully though CMS condition out to achieve full conditions. Serves as an active Governing Board member to multiple Kindred hospitals. Able to review and prepare facilities for both Laboratory and Hospital Joint Commission accreditation.

CONVERGENCE HEALTH CONSULTING, INC.
SENIOR CONSULTANT (JULY 2007- FEB 2009)
ANAHEIM MEMORIAL MEDICAL CENTER – INTERIM CONSULTING POSITION AS RISK MANAGER – Interim Risk Manager to develop complaint and grievance process to meet CMS requirements; continued to fill position as the Risk Manager. AMMC was in the process of a sale. In Oct. advanced to Chief Nursing Officer.

KINDRED HEALTH CARE
REGIONAL DIRECTOR CLINICAL OPERATIONS (2004-2007)
Promoted from COO role (see next)
Had direct oversight over 6 hospitals in the West Region. Assisted all 24 facilities in the West Region as needed for operations support, plan implementation, developing plans of correction. Ensured Joint Commission re-accreditation of 3 facilities that experienced a denial of accreditation. Assisted 2 other facilities in Conditional Accreditation to achieve full Joint Commission accreditation. Assisted one hospital in Joint Commission re-accreditation.

KINDRED HOSPITAL ONTARIO
CHIEF OPERATIONS OFFICER (1996 –SEPTEMBER, 2004)
Had responsibility for all clinical areas including Nursing, Pulmonary, Rehabilitation, Dietary, Radiology, Laboratory, Housekeeping, Social Services, Surgery, Infection Control, Employee Health and Pharmacy.
Chair multiple committees including Quality Council, Policy and Procedure, Employee Activities, Bioethics, Environment of Care, ICU and Medical Records committees. Member of Medical Executive Committee and Governing Board. Served as interim CEO for 8 months until CEO was recruited.

ST. BERNARDINE MEDICAL CENTER, SAN BERNARDINO, CALIFORNIA
Director Patient Care Services (1989-1996)
Started as a manager in 1989 for a 17 bed Intensive Care Unit and 12 bed Coronary Care Unit. In 1992 became Director of Nurses, reporting to the Chief Nurse Executive. Areas included ICU/CCU, Telemetry, Intermediate Care, Medical-Surgical Units, Peri-Operative Surgery, Out Patient Surgery Center, Central Supply, Diabetes Health Services, Hemodialysis and Nursing Services. (1994). Included responsibility for 250 FTE's and 10 managers. Chaired Nursing Policy and Procedure Committee. Active on multiple committees, including Quality Council, Medical Staff Committees, such as ICU and Surgery Committees.

QUEEN OF THE VALLEY HOSPITAL, WEST COVINA, CALIFORNIA
Unit Coordinator, 1981-1989
Manager for the Intermediate Care Unit, an18 bed unit with telemetry monitoring. Responsibilities included interviewing, hiring, firing and counseling. Coordinated patient care and other activities. Worked as staff nurse in the same area for the first three years. Also covered House Supervisor Position.

SANTA TERESITA HOSPITAL, DUARTE CALIFORNIA
Paramedic Liaison Nurse, 1976-1981
Worked as staff nurse in the Emergency Department for the first three years. Promoted to Paramedic Liaison Nurse. Created and developed this position based on L.A. County Health Services Guidelines. Coordinated paramedic and mobile intensive nurse (MICN) training.

LIFE FLIGHT OF SOUTHERN CALIFORNIA
Flight Nurse, Fixed Wing, 1978-1983

HURON ROAD HOSPITAL, E. CLEVELAND OHIO
Circulating and Scrub Nurse, 1974-1976

EDUCATION

CAL STATE UNIVERSITY, SAN BERNARDINO *Masters of Science in Health Services Administration, 1997*

SOUTHERN ILLINOIS UNIVERSITY, CARBONDALE INDIANA
Bachelor of Science in Health Care Management, 1989

HURON ROAD HOSPITAL SCHOOL OF NURSING, EAST CLEVELAND, OHIO
Diploma, Registered Nurse, 1974

EXHIBIT "C" TO VON CROCKETT TESTIMONY

Los Angeles Community Hospital
2016 Performance Improvement Plan

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Behavioral Health Unit										
BHU - Nursing										
1. AMA			•	2%	1,2,5,7	AMA/AWOL	# AMA/AWOL / #DC	AMA/DC Log	UR/QC, MEC, GB	Data by month – Reported minimum of Quarterly
2. Restraints			•	20%	1,2,3,5,7	Providing alternate intervention before restraint application	# Restraint/month	Restraint Log monthly	UR, QC, MEC, GB	Data by month – Reported minimum of Quarterly
3. Falls			•	0%	1,3,4,7	Prevention of fall, fall assessment, fall with and without injury	# Fall	Incident reports	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
4. Crash Cart			•	100%	1,7	Crash Carts equipment checked nt and availability of non-expired medical supplies	# of crash cart checks/ # days in a month	Crash carts monthly check log	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
5. Hand Hygiene			•	100%	1,3,4,7	Hand Hygiene by hand washing and or alcohol	/ # of complaints / # HH observed	HH monitoring tools monthly	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
6. Effectiveness of Pain Management			•	100%	1,2,3,4,5,6,7	Pre and post pain assessment documentation	• Pre Pain assessment/ # pain meds • Effectiveness of pain management / # pain medication administered	Medical Record Review	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
Dietary										
1. RD timeless	•	•	•	98	7	Providing practitioner specific data	#initial assessments, follow ups, calorie counts, consults done by deadline/# total patients due	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
2. PO intake of meals recorded	•	•	•	90	5	Providing practitioner	#patients with recorded PO intake in EMR/#	RD productivity	QC	Data by Month – Reported Minimum of

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						specific data	total patients with oral diet	log/EMR		Quarterly
3. Correct diet order	•	•	•	100	1, 5	Providing practitioner specific data	# diets ordered correctly (diets ordered from approved list, diets discontinued, etc.)/total # of patients seen	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
4. RD recommendations taken within 48 hrs. – (LACH/NCH)	•	•		70	1, 5, 7	Providing practitioner specific data	#nutrition recommendations taken within 48 hours/total # of recommendations made	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
5. Actual weight obtained at admit – (LACH/NCH)	•	•		75	1, 5	Quality assurance	#accurate weights obtained at admit/total # of patients seen	RD productivity log/EMR	QC, CNO	Data by Month – Reported Minimum of Quarterly
6. Test Trays (include visual presentation, temperature, taste, timeliness)	•	•	•	95	1, 5, 6	Quality assurance	Total points scored/total possible points	Test Tray evaluation log	QC	Data by Month – Reported Minimum of Quarterly
7. Tray Accuracy Analysis – (LACHB)			•	90	1, 5, 6	Quality assurance	# of accurate trays/total # of tray observed	Tray Accuracy Log	QC	Data by Month – Reported Minimum of Quarterly
Health Information Mgmt.										
1. Medical Records Delinquency				50%	7	EHR System Monthly Delinquent Numbers	Total Number of Incomplete Medical Records Over 14 days from discharge/visit / Total Number of Inpatient Discharges, Total Number of Outpatient Surgeries, Total Number of ED Visits	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
2. Inpatient H&P completed within 24 hours of admission				100%	1, 2, 5, 7	Check every inpatient chart	Total number of H&P not completed within 24 hrs / Total number of admissions	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
3. Valid H&P completed within 24 hours prior to surgery.				100%	1, 2, 6, 7	Check every OPS chart	Total number of H&P not completed prior to surgery / Total number of OPS	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
4. Psychiatric Evaluation completed within 24 hours of admission				100%	1, 2, 5, 7	Check every inpatient chart	Total number of PE not completed within 24 hrs / Total number of admissions	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
Human Resources										
1. Licensure/Certification	•	•	•	100%	1,7	Provide Mgmt. with specific data	#of lic/cert compliance/#of lic/cert due for the month	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
2. Performance Evaluations	•	•	•	90%	5,7	Provide Mgmt. with specific data	#of evals completed/#of evals due	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
3. General Orientation Compliance	•	•	•	100%	7	Provide Mgmt. with specific data	#of attendees/#of new hires for the month	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
4. Annual Competency	•	•	•	90%	1,7	Provide Mgmt. with specific data	#of competency completed/#of competencies due	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
5. Annual Health Questionnaire	•	•	•	95%	1,7	Provide Mgmt with specific data	# of questionnaire due/#of questionnaire completed	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
Infection Control										
1. Invasive Devices	•	•		100%	3,5,7	Central line blood stream infections	Numerator: All CLBSI cases in all ICU,s in the organization. Denominator: # of central line days in all ICU,s	ICU Log book	P&T,QC, MEC.	Data by Month – Reported Minimum of Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
2. Hospital acquired MRSA laboratory confirmed blood stream infections.	•	•		100%	3,5,7	Positive blood culture after 48 hours of admission	**Numerator:** # of hospital acquired MRSA laboratory confirmed **Denominator:** Total number of patient days	Daily laboratory results	P&T,QC, MEC,	Data by Month – Reported Minimum of Quarterly
3. C.difficile	•	•		100%	3,5,7	All positive cultures after 48 hour of admission	**Numerator:** Laboratory confirmed positive cultures. **Denominator:** Total number of patients days	Daily laboratory results	P&T,QC, MEC	Data by Month- Reported Minimum of Quarterly
4. Prevalence Rate	•	•		100%	3,5,7	Final Surveillance	**Numerator:**# of hospital acquired infections. **Denominator:** # of patient days	Daily surveillance activities	P&T, QC MEC	Data by Month- Reported Minimum of Quarterly
5. Reportable Conditions	•	•		100%	1,3,5,7	Daily surveillance	Numerator: # of patients admitted with reportable conditions	Daily surveillance	P&T,QC, MEC	Data by Month- Reported Minimum of Quarterly
Laboratory	•	•								
1. Turn Around Time Urgent Care- Troponin	•	•		100%	1	2	# test meets criteria/ total test	Lab Data	QA	Q
2. Critical Read back Documentation	•	•		100%	1,3	3	# meets criteria/ # total criticals (days)	Lab Data	QA	Q
3. % Blood Cultures Not Contaminated	•	•		>97%	1,3,5	5	# non-contaminatec blood cultures/ blood cultures drawn	Lab Data	QA	Q
4. Transfusion Services	•	•		Various	1,7	6,7	NA	Lab Data	QA	Q
5. Phlebotomy- Proper Identified or Labeled Specimens	•	•		100%	1	1	# properly identified/ labeled/# specimens	Lab Data	QA	Q
6. Lab Quality Control- Problems Resolved	•	•		100%	1,7	6,9	# days meeting criteria/ # days	Lab Data	QA	Q
7. Proficiency Testing- Transfusion	•	•		100%	1,7	6,10	# meets criteria/ # events	CAP Data	QA	Q
8. Proficiency Testing- Other Lab Test	•	•		>80%	1,7	1,6	# meets criteria/ #events	CAP Data	QA	Q
9. No Significant Variations Between Pathological Findings and Clinical Diagnosis for Surgical	•	•		100%	1,7	2,4	# that correlate/ # cases	Pathology	QA	Q

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Cases										
10. No Pathological Diagnostic Discrepancies	•	•		100%	1,7	4	# cases that meet/ cases reviewed	Pathology	QA	Q
11. Glucose Meter: Documentation of steps taken for Criticals as entered on meter	•	•		95%	1	3	Totals that meet criteria/ total of critical results	Lab Data Rals	QA	Q
Medical Staff										
1. Proctoring Evaluation completed within 3 months of practitioners' provisional appointment	•	•	•	100%	2 (NEW)	Practitioner Proctoring Completion	# Reports Submitted/ # Practitioners due for evaluation	Provisional Appointments Report	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
2. Ongoing Professional Practice Evaluation at Time of Reappointment/Bi-Annual Evaluation Reports Provided by: • Case Management • Infection Control • Laboratory • Medical Records • Pharmacy • Quality Management PI	•	•	•	100%	5	Obtaining Practitioner – Specific Data	# Reports Submitted/ # Practitioners due for evaluation	Reports received by various departments	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
Nursing										
ER										
1. Patient Throughput	•			10% decrease	Patient Satisfaction	Door to disposition time	Current time/2015 time	ED Logs	QC	Monthly
2. EMTALA	•			100%	Patient/ Organizational Safety	EMTALA Audit Elements	# Elements Achieved/Possible	Patient Chart	QC	Monthly
3. Triage time by RN was 15 minutes after arrival.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
4. MSE Completed by ER Physician 30 minutes after registration.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
5. Patient should be in bed 1 hour after ER MD makes a decision to admit as inpatient.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
ICU										
1. Pain Management	•			100%	Patient Safety	Pain Assessment/	# audit elements achieved/ # possible	30 Patient Records/Mont	QC	Monthly

00576

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						reassessment/ documentation		h		
2. Moderate Sedation	•			100%	Patient Safety	Propofol sedation vacation	# daily "sedation vacations"/# days sedated	Patient chart	QC	Reported daily and to Quality Council monthly and to P&T monthly
3. Restraints - physical	•			0%	Patient Safety/Patient Rights	Absence of physical restraints	# physical restraints/# patients	Patient Chart and ICU Log	QC	Daily and to Quality Council monthly
4. Care Plan documented with pre-existing condition i.e. Dialysis patient		•		100%	2,7,1	Chart audit	30/30	Medical Record	QC	Monthly
5. Consent signed for Hemodialysis Prior to treatment		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
6. For Septicemia Core Measure patient, Lactic Acid is drawn		•		100%	7, 1	Chart audit	Per # of Septicemia admitted 100%	Medical Record	QC	Monthly
7. For Septicemia Core Measure patient, Blood Culture is obtained prior to administration of IV antibiotics		•		100%	7, 1	1:1 Observation	Per # of Septicemia admitted 100%	Direct Observation	QC	Monthly
Med/Surg/Tele										
1. Medication Administration	•			100%	Patient Safety	Timely administration – 1 hour before/after scheduled	# doses given as scheduled/ #doses	Patient Chart	QC	Weekly with report to Quality Council monthly
2. Assessment	•			100%	Patient Safety	Assessment completed/documented/policy	# completed/# patients	Patient Chart	QC	Weekly with report to Quality Council monthly
3. Care Plans	•			100%	Patient Safety	Care Plan initiated/policy	# initiated/ # patients	Patient Chart	QC	Weekly with report to Quality Council monthly
4. Restraints - Physical	•			100%	Patient Rights	Monitoring elements/policy	# elements achieved/ # possible elements	Patient Chart	QC	Daily with report to Quality Council monthly
5. Skin Integrity	•			0%	Patient	Development/p	# adverse alteration	Patient	QC	Weekly with report

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					Safety	rogression of adverse alteration in skin integrity	in skin integrity/ # patients with Braden Scale 18 or higher	Assessment/ Chart		to Quality council monthly
6. Care plan documented with pre-existing condition i.e., Dialysis patient		•		100%	2, 7, 1	Chart audit	30/30	Medical Record	QC	Monthly
7. Consent signed for Hemodialysis prior to treatment		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
8. Pain re-assessment after pain medication administration		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
9. Medication Pass		•		100%	2, 7, 1	1:1 observation	20/20	Direct Observation	QC	Monthly
Nursing Admin (LACH/NCH/LACHB)										
1 Current Evaluations	•	•	•	90%	Currently less than 20% are completed on time.	Completed and sent to HR by due date.	# on time completed/number to be done	HR evaluation list with due dates.	QC	Monthly
2. Registry Files	•	•	•	100%	Patient safety/regulatory risk	Registry files current/complete for each nurse who works in the hospital	#files completed/standard # staff assigned during2016	Registry sign-in log in Nursing Administration	QC	Quarterly
3. RN Recruitment/ Retention	•	•	•	18%	Patient safety from critical shortages	New Hires and turnover	# Terminations/# of RNs	HR	QC	Quarterly
4. Policy/Procedures Current	•	•	•	100%	Patient Safety	Current date and content	# Nursing departments with current date for review/revision/# of Nursing departments	P&P data base	QC	Quarterly
Pediatrics										
1. Age specific care	•			100%	Patient Safety/Right	Care matched to developmental	# Developmental age specific care	Patient Chart/Observ	QC	Weekly with report to Quality Council

005578

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					s	stage	plan/interventions/ # patients	ation/Pediatric unit log		monthly
2. IV Infusion Safe Guards	•			100%	Patient Safety	IV order/administration size appropriate	# accurate order/administered IVs/# IVs	Patient Chart/Observation	QC	Weekly with report to Quality council monthly
Patient Access										
1. EMTALA Log	•	•		100%	1, 2	LD, PI	Numerator: Total number of patients listed on EMTALA log/Denominator: Total number of patients listed on EMTALA log	EMTALA log	QC	Quarterly
2. Language Line	•	•		100%	1, 2	RI, PI	Numerator: Total Number of Completed Consent Forms in Patient Preferred Language Denominator: Total Inpatient Registrations	Optimum Registration System	QC	Quarterly
3. IMM: Signed, timed and dated			•	100%	2	RI, PI	Numerator: Correctly completed IMM Forms Denominator: 50 patients	Important Message from Medicate	QC	Monthly
4. Preferred Language Log			•	100%	2	RI, PI	Numerator: Preferred language on the face sheets and consent matching Denominator: 50 patients	Face sheet and Consent forms	QC	Monthly
Pharmacy										
1. Medication Errors	•	•		<3.8%	Indicator for patient safety measure by pharmacy	Error reporting by pharmacy/ Nursing	Number of reported errors/total # discharges	Pharmacy reports and Nursing reports	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
2. Adverse Reaction	•	•		<0.25%	Indicator for patient safety	Error reporting based on rescue	Number of ADRs/Total discharges	Pharmacy reports and Nursing	Director of pharmacy,	Daily of Director of Pharmacy, Monthly to QC and CNO

0679

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					measure by pharmacy	medication dispensed		reports	QC, CNO	
3. End Point Sterility Test	•	•		0%	Compliant to Board of Policy	Steriquot	# test failed/Total # of Test		Director of Pharmacy	Monthly
4. 30 min medication administration	•	•		>95%	Compliant to CMS	Random Chart Review	Specified med given within 30 min of the time due/Total number audited	Daily audit	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
5. Controlled Substances documentation in ED	•	•		100%	Compliant to CMS	Weekly Omincell report	# narcotic medications taken from omnicell that have matching entered orders for that patient/# audited	Weekly audit	QC, CNO	Weekly to Director of Pharmacy, Monthly to QC and CNO
6. ED drug dispensing for Pediatric patients	•	•		100%	Compliant to CMS	Daily Monitoring	Inappropriate orders/Total pediatric orders	Daily	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
7. Omnicell Override	•	•		100%	Compliant to CMS	Daily Monitoring	Complete orders/Total override	Daily audit	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
Physical Environment (EOC)										
1. Sixty (60) second response time for fire response personnel for false alarms and fire drills	•	•		85%	1,5	Staff Response	N- Fire Responses < 60 seconds D- Fire Responses	Drill Reports	EOC, QC, MEC	Quarterly
2. Reduce the number of recordable injuries by 5% from 2015	•	•		NCH: 12 LACH: 35	5	Safety	N- Number of Injuries D- Number of Days	HR	EOC, QC, MEC	Quarterly
3. Maintain level of patient falls at or below 2.8 benchmark fall rate per 1000 patient days	•	•		2.8	1, 6	Patient Handling	N- # of Patient Falls D- # of Patient Days	Quality Management	EOC, QC, MEC	Quarterly
4. Identified deficiencies on EOC rounds are corrected and documented as completed within 45 days	•	•		85%	5,1,6	Work Order Process	N- Deficiencies Identified D- Deficiencies Completed	EOC Rounds Survey Report	EOC, QC, MEC	Quarterly

0580

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
5. Reduce the number of theft types at Alta Los Angeles Hospitals by 10% from the total thefts reported in 2015.	•	•		LACH: 13 NCH: 13	1,6	Security	N- Thefts reported D- Thirteen	Security Reports	EOC, QC, MEC	Quarterly
6. 15% reduction in number of linen pounds per patient day from 2015	•	•		LACH: 11.1 NCH:1 1.75	4	Allocation	N- Soiled Linen lb D- Adj Patient Days	Angelica Satisfactory Report	EOC, QC, MEC	Quarterly
7. Conduct Patient Safety Drills Quarterly in Non-Common Areas.	•	•		100%	1	Staff Response	N- Drills Completed D- Drills Scheduled	Drill Report	EOC, QC, MEC	Quarterly
8. Safety check completion rates for vendor life support equipment devices.	•	•		100%	5	Staff Training	N- Equip. Checked D- Equip. Received	Vendor Equipment Log Book	EOC, QC, MEC	Quarterly
9. Safety check completion rates each month for vendor non-life support equipment devices.	•	•		95%	5	Staff Training	N- Equip. Checked D- Equip. Received	Vendor Equipment Log Book	EOC, QC, MEC	Quarterly
10. Completion Rate for Submitted Work Orders	•	•		90%	5,1,6	Work Order Process	N- W.O. Completed D- W.O. Submitted	Work Order System	EOC, QC, MEC	Quarterly
Quality/Risk Management										
LACH/NCH										
1. Response to Grievances within 7 Days	•	•		100%	2,5,6	Grievance Response	# Responses with 7 Days/Grievances	Grievance Log	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
2. All OPPE to Medical Staff by Deadline	•	•		100%	2,5	Providing Practitioner Specific Data	#OPPE Reports Submitted by Deadline/#OPPE Reports Due	List of Reports Completed/Med Staff List of Reports Due	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
3. #AMA OPPE to Medical Staff by Deadline	•	•		2%	1,3,5	Patients leaving AMA	# AMAs per admission	AMA Report from IT/Clarity	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
4. # Falls blow national benchmark	•	•		2.5%	1,3,5	Patients falls by unit/shift	# falls per admission	Fall Report from Clarity	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
5. Overall Mortality Rate below national benchmark	•	•		2.5%	3,5,7	Total number of deaths	# of deaths per 100 discharges	Mortality Report from IT	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
6. Core Measures	•	•		100%	3,5,7	AMI, STK, VTE continued: Add Sepsis	Meet CMS Standard requirement for # reviewed	Data from IT	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly

01581

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
7. Readmissions	•	•		<10%	3,5,7	Patient readmitted within 30 days for same diagnosis	Number readmissions for same Diagnosis	Data from IT; Input from DUI and CM	QC, MEC, GB	Data by Month—Reported Minimum of Quarterly
Radiology										
1. Radiologist required procedures performed in a timely manner	•	•		100%	2,5	Time procedure performed	# of timely procedures/ # of procedures	EMR/PACS	QC	Quarterly
2. Critical result documentation	•	•		100%	1,7	Document in report	# of critical results reported/ # of critical results	Transcribed reports	QC	Quarterly
3. Marker Use	•	•		95%	1,4	Marker use	# of radiographs with marker/ # of radiographs	Image Review	QC	Quarterly
4. Discrepancy in the ED physician and radiologist interpretation	•	•		95%	4,7	Reading Accuracy	# of interpretations with no discrepancies/ # of interpretations by the ED physician	Radiologist	QC	Quarterly
5. Radiation Exposure	•	•		100%	3,7	Exposure	# of staff without exposure issue/ # of staff monitored	Dosimetry reports	QC, EOC	Quarterly
6. Computerized Tomography Dose Reporting	•	•		100%	1,7	Dose	# of CT scans missing dose/ # of CT scans	PACS images	QC	Quarterly
7. Appropriateness of Nuclear Medicine Procedures	•	•		100%	1,7	Reason for Procedure	# of appropriate NM procedures/ # of NM procedures	Contracted Service Manager	QC	Quarterly
Rehabilitation Services										
Wound Care Therapy										
1. Identification, intervention, and documentation of pain during Rehab/WC encounter.	•	•		100%	1,2,5,6,7	Completion of pain parameter entry in all daily encounters including documentation of pain level, applicable treatment, and/or pt's rights to proceed or not.	#of complete pain parameter documentation entries/10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool ☐ ongoing ☑ new	QC Medicine	Quarterly
2. Prevention of pressure	•	•		LACH	1,2,5,6,7	Utilization of	#of hospital acquired	HAPU incident	QC,	Quarterly

01582

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
ulcers during hospital stay.				1.2% SA 0.1% NCH 0.8%		Braden Screening tool to identify patient with community PU. Monitoring of new pressure ulcer wounds not identified at admission. Tracking of HAPU using internal process.	pressure ulcers/1000 patient days.	reports. ☑ongoing ☐ new	Medicine	
3. Pressure Ulcer Prevention Program (PUPP) provided within 24 hrs upon admission, readmission, or transfer.	•	•		100%	1,2,5,6	Validation of Braden Screening tool compliance. Initiation of protocol supported with documentation.	#of PUPP provided within 24 hrs. upon admission, readmission, or transfer/ 10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool. ☑ongoing ☐new	QC, Medicine	Quarterly
Rehab Services										
4. Speech Therapy evaluation provided (within 48hrs) when ordered by MD.	•	•		100%	1,2,6,7	Gathering all new consults and checking if patient was seen within the timeframe.	# of Speech Therapy evaluations provided within 48 hours/#of total Speech Therapy orders.	HER, QI data gathering tool. ☑ongoing ☐new	QC, Medicine	Quarterly
5. Physical Therapy evaluation provided within 24 hrs. when ordered by MD to include a complete documentation such as: ✓ PT evaluation documentation ✓ PT goals ✓ Plan of Care ✓ Clarification of PT orders, if needed, with frequency, duration, and interventions.	•	•		100%	2,6,7	Gathering all new consults and checking if patient was seen within the timeframe with complete entries of documentation parameters.	# of Physical Therapy evaluations provided within 24 hrs. with complete documentation/10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool. ☑ongoing ☐new	QC, Medicine	Quarterly

01583

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
6. Rehabilitation (Recreation) Therapy Assessment completed by Therapy team within 72 hours of patient admission			•	100%	4,6,7	Patient's Rights and Provision of Care issues	Total # compliance/total # of medical records reviewed.	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
7. Rehabilitation Therapy Discharge Summaries completed within 72 hours of patient discharge.			•	100%	4,6,7	Patient's Rights and Provision of Care issues	Total # compliance/total # of medical records reviewed	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
8. Rehabilitation Services			•	100%	4,6,7	Patient's Right and provision of Care issues	Total # compliance/total # of medical records reviewed.	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
Respiratory										
LACH/NCH	•	•								
1. Ventilator Protocol	•	•		65%	1,6,7		# weaned/total monitored	Log	QC	Quarterly
2. Trach Changed within 30 days	•	•		95%	1,3,5,7		# done/total trach pts	Charting	QC	Quarterly
3. Assessments/Reassessments	•	•		95%	1,5,7		# done/total measured	Charting	QC	Quarterly
4. Trach Ties	•	•		95%	1,5,6,7		#done/Total	Charting	QC	Quarterly
5. Equipment Changes	•	•		95%	1,5,6,7		# changed/Total	Charting	QC	Quarterly
6. Crash Carts	•	•		95%	1,3,5,7		# done/total	Log Book	QC	Quarterly
7. Oral Care	•	•		95%	1,3,4,5,6,7		#documented/total	Observatio	QC	Quarterly
8. Charges checked and submitted	•	•		95%	4,5,7		# checked/total	Charting	QC	Quarterly
9. Tardiness	•	•		95%	1,7		Days tardy/total	JBDEV	QC	Quarterly
10. Attendance	•	•		95%	1,7		Days absent/total	Schedule	QC	Quarterly
11. Continuous Pulse Oximeters for Vents	•	•		100%	1,3,4,5,7		# on pts/total	Observatio	QC	Quarterly
12. Medications ordered for SAU	•	•		100%	1,4,6,7		Not ordered/Total	Log Book	QC	Quarterly
13. Bedside Reporting for Patients	•	•		95%	1,5,6,7		#RTs not compl/total	Observatio	QC	Quarterly
14. Temperature Log (Norwalk Hospital)	•	•		100%	1,2,5		# out of range/total	Log	QC	Quarterly
15. Critical Values Reported in a timely manner	•	•		95%	1,5,7		# out of range/total	Log	QC	Quarterly

01984

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Social Services										
1. Patients will be informed of their right to self-determination specifically their right to formulate an advance directive. Any patient that wants advance directive will be given information and will be followed up within 48 hours.	•	•		100%	5, 6, 7	2, 5	N: # of pts followed up within 48 hours of requesting info D: # of pts requesting information on advance directives	Advance Directives Log	QC	Q
2. All homeless patients will receive social work intervention to aid in placement. Documentation of intervention and final disposition will be reviewed for appropriateness.	•	•		100%	1,3	1,4	N: # of homeless pts seen by social services D: # of of homeless pts admitted	Admission screening	QC	Q
3. Homeless patients completing the informed consent form.	•	•		100%	1,3,5	1,5	N: # of homeless pts admitted to the hospital D: # of patients completing the form	Review of the medical record and forms	QC	Q
4. Psycho-Social Assessments completed with 72 hours of admission			•	100%	4, 6, 7	Social Services timely assessment of their patients	# Psycho-socials completed/Total # Psycho-socials for the sample	Medical Record	UR, QC, MEC, GB	Data by month – reported minimally quarterly
5. Important Message from Medi-Care-signatures obtained at time of admission and prior to discharge			•	100%	3, 4, 7	Timely notification of Medi-Care recipients of their rights.	# of signed IM message forms/Total # of IM messages for the sample	Medical Record	UR, QC, MEC, GB	Data by month reported minimally quarterly
6. Information provided to Care Giver when identified by the patient as part of the Aftercare Plan			•	100%	1, 2, 6, 7	Inclusion of patient Care Giver in the patient's aftercare	# of aftercare forms where Care Giver identified with information provided/Total # of aftercare forms where Care Giver is identified.	Medical Record	UR, QC MEC, GB	Data by month – reported minimally quarterly
Sub-Acute										

005685

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
1. MDS	•			100%	Patient Safety/Regulatory	Completion by required date	MDS forms completed on time/# patients	Patient Charts	Director of SA	Weekly with report to Quality Council Monthly
2. Care Plans	•			100%	Patient Safety/Regulatory	Care Plan initiated within specified time frame	# Completed by due date	Patient Charts	Director of SA	Weekly with report to Quality Council Monthly
3. Medication Administration	•			100%	Patient Safety/Regulatory	Timely administration – 1 hour before/after scheduled time	# doses given "on time"/ # doses	Patient Charts	Director of Pharmacy/Director of SA	Weekly with report to Quality Council Monthly
4. Infection Control	•			100%	Patient Safety/Regulatory	Handwashing	# washings/# required washings	20/week observations	Director of IC and Director of SA	Weekly with report to Quality Council Monthly
5.Care Plan/MDS congruence	•			100%	Patient Safety/Regulatory	Content congruence	# MDS/Care Plans congruent/# patients	Patient Charts	Director of SA	Monthly to Quality Council
6. Consent for Psych. Meds	•			100%	2	Documentation of obtained consent	# of Psych. Meds (last 30 days) /# of Consent Obtained	Chart	QC	Monthly
7. Side Effects Monitoring for Psych. Meds	•			100%	2	Side effects (S/E) monitoringevery shift	#shifts in the last 30 days of patients with Psych. Meds / # of S/E monitoring for Psych. Meds Q shift	Paper MAR	QC	Monthly
8. Foley Catheter (FC) with Indication for use	•			100%	2	Documentation of indication for FC use	# of FC in use (last 30 days)/ # of FC with indication	Chart	QC	Monthly
9. Use of Less Restrictive Measures Prior to Restraint use	•			100%	2	Documentation of less restrictive measures	# of restraints in use (last 30 days)/ # of documented less restrictive measures prior to use of restraint	Chart	QC	Monthly
10.Patency of Hemodialysis access	•			100%	2	Checking of bruit and thrill/	# of shifts requiring patency checks of	Chart	QC	Monthly

CR 5586

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						Patency of HD access site every shift	HD access requiring (last 30 days)/ # of actual Q shift monitoring of HD patient access			
11. PICC Line Consent Form	•			100%	2	Consent form obtained prior to PICC line insertion	# of residents with PICC lines (last 30 days) / # of PICC lines with consent form prior to insertion	Chart	QC	Monthly
12. Post Fall Assessment	•			100%	2	Documen-tation of post fall assessment after a fall	# of Fall in the last 30 days/ # of post fall assessments documented after a fall in the last 30 days	Chart	QC	Monthly
13. Matching of Range of Motion MD Orders on orders in the RNA treatment record	•			100%	2	RNA MD orders matches the tx orders on RNA sheets	# of RNA MD orders in the chart in the last 30 days/ # of RNA orders wherein MD orders matches the RNA orders on tx sheets	Chart	QC	Monthly
14. Treatment (Tx) orders are applied to patients with skin problems	•			100%	2	Skin problems with Tx orders	# of patients having Skin problems with treatment orders (every week in the last 30days)/# of patients with skin problems that received txs as ordered (every week in the last 30 days)	Chart	QC	Monthly
15. MDS Location of Assessment per CAA (Care of Assessment Area)	•			100%	2	CAA indicates location where assessment can be found	# of CAA in the last 30 days / # CAA with indication of the location where the documented assessment can be found	Chart	QC	Monthly

005787

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
16. Triggered CAA in the MDS with Corresponding Care Plans	•			100%	2	CAA triggered in the MDS are with Care Plans	# of CAA in the last 30 days/ # of CAA with complete care plans in the last 30 days	Chart	QC	Monthly
Utilization Review										
1. Initial Discharge Assessments are completed within 48 clock hours of patients' admission	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)	Allscripts Care Mgmt MCG/SS Discharge notes	URC and Quality /PI Committee	Q
2. Admission reviews are completed within 24 clock hours of admission and include required review elements.	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)	Allscripts Care Mgmt / Milliman Care EMR for scanned copy.	URC and Quality /PI Committee	Q
3. Patient Choice: The CM dept will provide the patient / patient representative with choices pertaining to their post hospital provider choices. This will be prior to DC and includes ,but not limited to acute inpt rehab ,home health, infusion therapy ,hospice care, skilled nursing care , custodial care,etc.. . Evidence of patient choice is documented in the DC plan.(The organization must respect the choice of the patient or authorized representative except in unusual circumstances.)	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)		URC and Quality /PI Committee	Q
4. Daily concurrent reviews are completed each calendar day and include the	•	•		95%	5	PC	N: # patients screened D: # cases reviewed	Allscripts Care Mgmt / Milliman	Allscripts Care Mgmt /	Q

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
essential elements of the review.							(30 cases / month)	Care Guidelines (MCG	Milliman Care Guidelines (MCG	
5. Important Message from Medicare is re-issued to all Medicare and Medicare eligible patients within 48 hours of discharge.	•	•		100%	2	RI	N: # IMMs re issued D: # (ALL Mcare / Mcare Mged care discharges / month)	Medical record audit(Original copy maintained in the patient's MR)	UMC and Quality Council	Q
1. Medi-Cal Denial Rate Acute/Administrative Days			•	<5%	7	PI	N: Total # of Medi-Cal days Denied D: Total # of Medi-Cal Days processed	Processed TARS	UMC, QC	Quarterly
2. Inpatient Length of Stay (Over Utilization)			•	<5%	7	PI	N: Total # of patients with LOS of>14 days D: Total # of discharges	Chart Review	UMC, QC	Quarterly
3. 1st Level Medi-Cal Appeals			•	Trend	7	PI	N: Total Days approved D: Total days Processed	Processed Appeals	UMC, QC	Quarterly

RATIONALE FOR INDICATOR SELECTION:

1. **Patient Safety Issue**
2. **Survey Finding**
3. **High Risk Process**
4. **High Volume Process**
5. **Problem Prone**
6. **Patient Satisfaction Issue**
7. **Required Measure**

There may be more than one rationale for a single indicator. Survey findings should be first priority.

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Quality Assessment and Performance Improvement Indicators for 2016 (revised as of 3/23/2016)

Note: Indicators are to be selected from this list. All indicators are not meant to be monitored at all times

No	Name	Definition	Target*	Accountability	Prioritization Criteria**	Reporting	Comment
Significant Adverse Occurrences							
1	Sentinel Event (Never Events)	Event leading to death or significant impairment (per Sentinel Event Policy) includes Near Misses (may be reported under significant events on scorecard)	0%	Risk Manager	XX, R, P, C	Quality Steering Committee (QSC) Medical Executive Committee (MEC) Board of Trustees (Board) [Monthly until resolution]	Each sentinel event is reported. The root cause analysis and prevention interventions are also reported.
2	Event Reporting Frequency (RCA)	Number of events reported of the following types: Medication-Related; Other significant	0%	Risk Manager	XX, R, P	QSC, MEC, BOARD [Monthly]	The focus will be to increase reporting of issues
3	Regulatory Citations	Issues identified in this category are monitored until sustained improvement is shown for a minimum of 3 months	TBD	TBD	TBD	TBD	TBD
Patient Safety							
4	Inpatient Falls per 1000 patient days	Numerator: Number of inpatient falls reported during the month Denominator: number of inpatient days per month X 1000.	0.35	Risk Manager	XX, R, P, V	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
5	Patient falls leading to injury requiring treatment	Number and brief description of the circumstances surrounding any inpatient or outpatient fall that required medical treatment	N/A	Risk Manager	XX, R, P, V	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee the effectiveness of corrective actions
Infection Prevention							
6	MDRO Infection Rate	Numerator: Number of cases (HAI) Denominator: 1000pt days	TBD	Infection Control Practitioner	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
7	Surgical Site HAI rate	Numerator: Number SSI Denominator: per 1000 clean cases (targeted/specific cases only)	TBD	Infection Control Practitioner	R, C, P, S	QSC, MEC, BOARD [Quarterly]	Surgical procedures for review should be related to capture the spectrum of clinical services and operative areas
8	Ventilator Associated Event Rate	Numerator: Number of ventilator associated event infections Denominator: Number of ventilator patient days X 1000	TBD	Infection Control Practitioner	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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** Prioritization Criteria: XX = Required by External Authorities, R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence, E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

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9	Central Line/Catheter Related Sepsis Rate	Numerator: Number of CLABSI Denominator: Number of line insertion patient days X 1000	TBD	Infection Control Practitioner	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
10	MRSA Rate	Numerator: Number of cases (HAI) Denominator: 1000 pt days ❖	TBD	Infection Control Practitioner	R, P, C, S	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
11	C. difficile Rate	Numerator: Number of cases Denominator: 1000 pt days ❖	TBD	Infection Control Practitioner	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
12	Rate of Compliance CDC Hand Hygiene Requirements	Numerator: Number of observations when the caregiver performed hand hygiene per CDC guidelines. Denominator: number of observations (opportunities)	100%	Infection Control Practitioner	XX, R, P, V	At least ten observations per month QSC, MEC, BOARD and Infection Control [Quarterly]	Observations should be rotated to cover all settings and all disciplines
			Organ / Tissue Donation				
13	Notification of OPO of imminent patient death/actual death	Numerator:# of OPO contacts within time frames per policy Denominator: # of deaths per month	75%	Risk Manager	XX, E	QSC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
			Environment of Care				
14	Emergency Generator Testing 12 tests required per year with intervals of not less than 20 days and not more than 40 days	Numerator: # of tests conducted at required load Denominator: # of tests required	TBD	Plant Operations	XX, R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
15	Preventative Maintenance on High Risk Equipment	Numerator: # of PM equipment checks per program Denominator: # of PM equipment observations conducted	95%	Biomed	R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
16	Emergency Management Activation	2 per year	TBD	Plant Operations	XX, R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions

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17	Emergency Management Employee Education	**Numerator:** # of employees correctly describing their role in the event of an internal/external disaster **Denominator:** # of employees interviewed	>90%	Plant Operations	R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
18	Fire Drills	**Numerator:** 1 fire drill per quarter per shift conducted **Denominator:** 12	100%	Plant Operations	XX, R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
19	Staff knowledge of fire plan	**Numerator:** # of staff articulating fire plan components correctly **Denominator:** # of staff queried	>90%	Plant Operations	R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
20	Preventative Maintenance on Life Safety System	**Numerator:** # of PM on Fire System **Denominator:** 4 total Fire System PM Conducted	<95%	Plant Operations	R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
21	Life Safety Assessment Conducted for all construction/ renovation projects	**Numerator:** # of ILSM assessments conducted **Denominator:** # of construction/renovation projects initiated	100%	Plant Operations	XX, R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
	Patient Complaints / Grievances						
22	Timely Patient Grievance Response Rate	**Numerator:** # of patient grievances responded to w/7 days **Denominator:** # of grievances reviewed	TBD	Patient Advocate	R, P, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Clinical Excellence / Operational Quality						
	CMS Core Measures						
23	Compliance with Core Measures See core measure descriptions	Indicator sets for AMI, Pneumonia, CHF with related core measure criteria will be reviewed on a quarterly basis(see attached) ❖	TJC Reported mean	Quality Director	XX, V, C, E	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	HCAHPS						
24a	Patient Satisfaction, overall level of care, Inpatient	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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24b	Patient Satisfaction, overall level of care, ED	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
24c	Patient Satisfaction, overall level of care, OP	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	HBIPS						
25a	HBIPS-1	Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25b	HBIPS-2	Hours of physical restraint use	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25c	HBIPS-3	Hours of seclusion use	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25d	HBIPS-4	Patients discharged on multiple anti-psychotropic medications	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25e	HBIPS-5	Patients discharged on multiple anti-psychotropic medications with appropriate justification	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25f	HBIPS-6	Post-discharge continuing care plan created	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25g	HBIPS-7	Post discharge continuing care plan transmitted to next level of care provider on discharge	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Contract Services						
26	Evaluation of Contracted Services	Numerator: Number of Contracted Services Evaluated Denominator: Total number of Contracted Services	Corp mean	COO	XX	PICC, Board (Annually)	Performance Improvement Coordinating Council will oversee the effectiveness of corrective actions
27	Effectiveness of Contracted Services	Numerator: # of services with positive evaluation Denominator: # of contract services	95%	COO	XX	PICC, Board (Annually)	Performance Improvement Coordinating Council will oversee the effectiveness of corrective actions
	Surgery/GI Lab						
28	Sedation Outcome (Use of Reversals)	Numerator: Number of sedation cases with reversal agents used Denominator: Total sedation procedures performed	0%	GI Laboratory and Sedation Team Director	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions Will refer physician identified trends to Peer Review Committee for review, determination and action as necessary

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29	Unplanned Returns to the OR	Numerator: Number of unplanned patient returns to OR for surgical procedure during same admission as initial procedure Denominator: Number: Number of surgical cases performed ✧	TBD	Surgery Director	R, P, C, S	QSC,, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review , determination and action as necessary*
30	PI Project Status Temp and Humidity in the OR suites	Numerator: # of times temp and Humidity out of range Denominator: # of times temp and humid measured	100%	Surgery Director	R, P, V,C, E,	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
31	Sterilization of Surgical Instruments PI Project	Numerator # of instrument trays with no evidence of discoloration post sterilization/Denominator# of instrument trays inspected	100%	Surgery Director	R, P, V,C, E.	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
32	ALOS in PACU	Average Length of Time in Minutes	TBD	Surgery Director	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
			Health Outcomes / Complications –1				
33	Inpatient Mortality Rate	Numerator: Number of inpatient deaths Denominator: Number of patient days per month X 1000	TBD	Quality Director	R, V, P, C, S	QSC, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review, determination and action as necessary**
34	Postoperative Mortality Rate (new)	Numerator: Number of mortalities post surgical procedure Denominator: Total number of surgical cases performed	TBD	Quality Director	R, V, P, C, S	QSC, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review, determination and action as necessary
			Health Outcomes / Emergency Department				
35	Emergency Department LWBS rate	Numerator: Number of patients leaving ED WBS Denominator: Number of ED patient visits X 1000	<2%	ED Manager	R, V, P, C, S	QSC, BOARD Quality Steering Committee [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
36	Door to Physician Time	Average Monthly Time in Minutes	TBD	ED Manager	R, V, P, C, E	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
37	Door to Disposition Time	Average Monthly Time in Minutes	TBD	ED Manager	R, V, P, C, E	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
38	# of Pts in ED >4 hrs & ≤ 6 hrs	Numerator: # of registered pts in ED >4 hrs. but ≤ 6 hrs Denominator: # of ED visits X 1000 ✧	90%	ED Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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39	ED Adult Patient Average Length of Stay	Average Length of Time in Hours	TBD	ED Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Health Outcomes / Complications – Behavioral Health/IDP							
40	Assaultive behavior pt. vs. pt	Numerator: # of pt vs pt assaults Denominator: 1000 pt days:	<30%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
41	Assaultive behavior pt vs st.	Numerator: # of pt vs st assaults Denominator: 1000 pt days::	<15%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
42	Assaultive Behavior st. vs. pt	Numerator: # of st vs pt assaults Denominator: 1000 pt days:	0%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
43	Patient rights: appropriate discharge	Numerator: # of appropriate discharges/ Denominator: # of discharged patients	2%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
44	Patient Rights: appropriateness of holds	Numerator: # appropriate holds Denominator: # of pt holds	<5%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
45	Patient Rights: Timely removal of holds	Numerator: # of timely removal of holds /Denominator: # of holds removed	TBD	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
46	Patient Rights: Use of seclusion/restraints	Numerator: # of pt in restraint/seclusion/ Denominator: 1000 pt days	90%	BHU Nursing Manager	R, V, C, S	Quality Steering Committee	Quality Steering Committee will oversee the effectiveness of corrective actions
47	Patient Rights: Privacy	Numerator: # of pt denied privacy Denominator: 1000 pt days:	volume	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Medical Staff (new)							
Other medical staff indicators determined by individual departments and services and reported to individual department QAPI meetings with routine reporting format							
Resuscitation							
48	Cardiopulmonary Arrests	Numerator: Number of cardiopulmonary arrests Denominator: 1000 patient days	Trend	ED Director	R, P, C, E, S.	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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49	Rapid Response Team (REACT Team) Effectiveness	Numerator: Number of Rapid Response Team responses w/in 4 minutes Denominator: RRT calls per month (per reporting period)	100%	ED Director	R, V, P, C, E	Code Blue Team, QSC, MEC, Board (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of Rapid Response Team responses with transfer to higher level of care Denominator: RRT calls	Trend	ED Director	R, V, P, C, E	Code Blue Team, QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
50	Resuscitation Outcome – Code Blue Efficiency	Numerator: Number of codes where all efficiency criteria is met Denominator: Total number full code arrests	100%	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of codes with patients surviving code Denominator: Number of full code arrests	Trend	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of codes with patients surviving to discharge Denominator: Number of full code arrests	Trend	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
Patient Satisfaction HCAHPS							
51	Patient Satisfaction, overall level of care, inpatient	Percent of patients indicating positive/slightly positive score*	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
52	Patient Satisfaction, overall level of care, ED	Percent of patients indicating positive/slightly positive score*	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
53	Patient Satisfaction, overall level of care, OP	Percent of patients indicating positive/slightly positive score*	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
Pain Management							
54	Pain Assessment	Numerator: Pain Assessment per policy Denominator: Number of observations		Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
55	Pain Re-Assessment	Numerator: Pain Re-assessment post intervention Denominator: Number of observations		Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
Hospital Acquired Pressure Ulcers							
56	Prevention of Hospital Acquired Pressure Ulcers	HAPU prevalence -overall	0.xx per CalNoc	Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD (Quarterly)	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions

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		HAPU prevalence - Rehab	0.xx per CalNoc	Nursing Admin	H, P, V, C, S	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions
Restraint Usage							
57	Restraint Prevalence	Restraint Prevalence – overall	K.xx per CalNoc	Nursing Admin	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions
58	Restraint Usage – Appropriateness of order (Physician) per policy	Numerator: Number of orders for restraint meeting restraint criteria per policy Denominator: Total number of orders for restraint	100%	Nursing Admin	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
59	Restraint Monitoring (Nursing) per policy	Numerator: Number of restraint records meeting monitoring criteria Denominator: Total number of restraint records reviewed *each episode of restraint reviewed – reported as variance per record ❖	100%	Nursing Admin	R, P, C, S	QSC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Medication Use							
60	Unit based Pharmacy Medication Error Rate	Numerator: total number of medication errors occurring in patient care areas Denominator: Total medications dispensed (or per 1000 medications dispensed) ❖	TBD	Pharmacy Director	R, V, P, C, E, S	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
61	Internal Pharmacy Medication Error Rate	Numerator: total number of internal pharmacy medication errors identified Denominator: Total number of drugs prepared for dispensing (or per 1000 drugs dispensed) ❖	TBD	Pharmacy Director	R, V, P, C, E, S	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions taken by Pharmacy
62	Adverse Drug Reaction Rate	Numerator: Number of adverse drug reactions Denominator: Number of medications administered ❖	TBD	Pharmacy Director	R, P, C	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
63	MERP program	See MERP Indicators per Facility		Pharmacy Director			

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R

Monthly statistical calculations unless otherwise stated

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Medical Records							
64	Medical Records Meeting Review Criteria (timeliness, legibility, authentication of data)	Numerator: Number of records meeting criteria at the 100% level Denominator: Random 30 record audit	90%	HIM Director	P, C, E	HISC, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
65	Medical Record Delinquency Rate	Average monthly discharges over the past 4 quarters Not greater than 50% of the AMD rate and no single quarterly measurement greater than 50% of the AMD rate	* not < 50%	HIM Director	XX, P, C, E	HISC, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
66	H&P Content per Medical Staff requirements	Numerator: Number of H&Ps performed Denominator: # H&Ps meeting MEC requirements ❖	TBD	HIM Director	P, C, E	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Laboratory							
67	Crossmatch to Transfusion Ratio	Numerator: Number of units ordered for crossmatch Denominator: number of cross matched units transfused	2:1	Clinical Laboratory	R, V,C	QSC, MEC, BOARD [Quarterly]	Negative trends will be analyzed with drill down to identify ordering issues – analysis will include all areas where cross match is ordered
68	Transfusion reaction rate	Numerator: Number of identified hemolytic transfusion reactions Denominator: Number of units transfused	0%	Clinical Laboratory	R, P, C	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee action plan for investigation
69	Average time of reporting of critical results	Mean time from resulting availability to notification of the responsible practitioner (physician or other practitioner who may initiate appropriate intervention) ❖	TBD	Clinical Laboratory	XX, R, P, V	QSC, BOARD All "tier 1" critical non-laboratory testing results Quality Steering Committee [Quarterly].	Quality Steering Committee will oversee the effectiveness of corrective actions
70	Discrepant Pathology Reports		0%	Clinical Laboratory	R, P, C	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee action plan for investigation
Utilization/Case Management							
71	Appropriateness of Patient Discharge	Numerator: Number of inpatient readmissions within 30 days of discharge for AMI, HF, CAP Denominator: Total number of discharges per month AMI, HF, CAP	TBD	Case Manager	V, C, E, S	QSC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
72	Appropriateness of care and treatment – Medicare specific	Numerator: Number of Medicare denials Denominator: Total number of Medicare patient discharges per month	TBD	Case Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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73	Appropriateness of care and treatment – Medicaid specific	Numerator: Number of Medicaid denials Denominator: Total number of Medicaid patient discharges per month	TBD	Case Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Employee Health							
74	Employee Influenza Vaccination Compliance	Numerator: # of staff who rcvd influenza vaccination Denominator: total number of staff		Director of Infection Control	XX, R		
Dialysis Services							
75	Contract Service Dialysis	See Standardized Indicators for Contract Services Dialysis		Nursing Admin			
76	Contract Service Dialysis	Numerator: Daily Patient Schedule Provided Denominator: Total number of Observations		Nursing Admin			
Food and Nutrition Services: Refer to Department Audits							
77	Contract Service Food and Nutrition	See Standardized Indicators for Contract Services Food and Nutrition		Director of Dietary			
78	Delivered Diet Tray Accuracy (new)	Numerator: Number of accurate meal trays delivered to unit Denominator: number of meal trays delivered	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
79	Food Safety – Sanitary, Storage and Preparation (Sanitation)	Numerator: Number of Compartment Sinks with Correct Temperature for Sanitation Denominator: number of Compartment Sinks Tested for Correct Temperature	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
80	Food Safety – Sanitary, Storage and Preparation (Safe Storage – Temperature)	Numerator: Number of Refrigerator and Freezer Logs with Temperatures within Range Denominator: number of Refrigerator/Freezer Logs Reviewed	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
81	Food Safety – Sanity, Storage and Preparation (Safe Preparation – Hot Food Cooling Process)	Numerator: Number of Hot Food Cooling Items Within Temperature Range Denominator: Number of Hot Food Items Cooled and with Temperature Checks	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
Imaging Services							
82	Dosimeter Badge Readings	Radiology Reports to QC with fall outs, posted for staff and F/U with employee	NA	Director of Imaging	XX	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")

** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

01599

83	Result Discrepancies/Re-reads	# of result discrepancies/ Total# of radiology reads/month	<5%	Director of Imaging	R, P	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
84	Radioactivity Monitoring	Numerator: The number of environmental swabs without radioactive traces. Denominator: The number of environmental swabs taken	100%	Director of Imaging	XX, R, V,P, C,E	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
	Rehabilitation Services (Physical Therapy and Habilitation Services)						
85	Functional Independence Measure Scoring (FIMS)	Numerator: # of pts with FIMS scoring improving to < national benchmark and range Denominator: Number of FIMS scores measured	*target specific to dx process – national average 29	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
86	Rehabilitation Patients Discharged to Community	Numerator: # of rehabilitation patients discharged to the community Denominator: # of patient discharges	72	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
87	Therapy Assessments	Numerator: # of physical therapy evaluations performed within time frame per policy criteria Denominator: # of physical therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: # of speech therapy evaluations performed within time frame per policy criteria Denominator: # of speech therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: # of occupational therapy evaluations performed within time frame per policy criteria Denominator: # of occupational therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

01600

Respiratory Therapy Services							
88	Arterial Blood Gas Management	Numerator: # ABGs resulted within 10 minutes of STAT draw Denominator: # of ABG STAT specimens requested included in study	100%	Respiratory Therapy Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
89	Timeliness of Treatment	Numerator: # of Missed/Delayed Treatments Denominator: # of treatments to be administered	0%	Respiratory Therapy Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Outpatient Services/Spine Clinic							
90	Medication Reconciliation	Numerator=# of medication recon forms completed with allergies identified/Denominator # of recon forms obtained/month	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
91	Medication Reconciliation	Numerator= # of Med recon forms sent to internist/Denominator = # of patients referred to internist	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
92	Wait Times	Numerator # of patients seen by physician within 20 minutes of arrival Denominator # of patients seen in center /month	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Outpatient Services/Cardiology Clinic							
93							
94	Post Procedure Pathology Reports	Numerator: # of post-procedure pathology reports available for patient visit/Denominator: # of post-procedure patient visits	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Final Read Cardiology Test Results	Numerator: # final-read cardiology test results available for patient visit/Denominator: # of cardiology results available for patient visit/month	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Wait Times	Numerator: # of patients seen by physician within 20 minutes of arrival Denominator # of patients seen in center /month Denominator:	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Environmental Services							
95	Contract Service EVS	See Standardized Indicators for Contract EVS Services					

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")

** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

01601

96	Cleanliness and Sanitation	**Composite Score** **Numerator:** # Areas Inspected Properly Cleaned and Disinfected **Denominator:** # of Areas included in Inspection	95%	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: SPD Terminally Cleaned per policy **Denominator:** # of observations	95%	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
		Composite Score **Numerator:** # Areas Inspected for Positive Glow Verification (effective disinfection) **Denominator:** # of Areas included in Inspection	TBD	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
Performance Initiatives/Projects							
97	Rate of compliance with structured patient hand-off process	**Numerator:** Number of observations of patient hand-offs during which the hospital's structured process was followed. **Denominator:** number of patient hand-offs observed ❖	TBD	Quality Director	R, P, V	QSC, MEC, BOARD 10 hand-offs per month Quality Steering Committee (Quarterly)	Sampling should focus on various types of hand-offs.

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")

** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

01602

PREFILE TESTIMONY OF MITCHELL LEW, M.D.

DEPARTMENT OF PUBLIC HEALTH	:	**DOCKET NO. 15-32017-486**
OFFICE OF HEALTH CARE ACCESS	:	
	:	
OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-02**
	:	
IN RE: GREATER WATERBURY HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**April 26, 2016**

PRE-FILED TESTIMONY OF MITCHELL LEW, M.D.

I. Introduction

My name is Dr. Mitchell Lew and I am the President of Prospect Medical Holdings Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") regarding the proposed acquisition of assets of Greater Waterbury Health Network, Inc. ("GWHN"), including The Waterbury Hospital ("Waterbury"), by PMH. Specifically, I will address PMH's proprietary Coordinated Regional Care ("CRC") model and its ability to drive significant improvement in healthcare to the GWHN community.

Professional Role

In my role as President of PMH, I oversee PMH in its efforts to integrate our regional delivery systems among physicians, hospitals and payors. This includes the development, implementation and oversight of PMH's CRC delivery systems in each of its regional markets. Prior to my current role, I served as CEO of Prospect Medical Systems and Prospect Medical Group, our management service organization and independent practice association, respectively.

Summary of PMH and CRC

PMH is a healthcare services company that owns and operates numerous health care systems across the nation working to benefit patients who access healthcare in our service areas.

PMH aligns its hospitals and physicians under a model referred to as the CRC model. CRC provides clinical integration among hospitals, physicians and other medical, social and community providers and works closely with health plans and other payors under a value-based, global risk reimbursement payment system. The goal is to achieve the triple aim of improved patient care and experience, better patient health, and lower costs.

PMH approaches each market by implementing three (3) simultaneous work streams. The three work streams are: (i) regulatory infrastructure; (ii) provider network development; and (iii) health plan engagement. The first work stream involves investigating and developing the regulatory infrastructure necessary in order for providers to assume and manage value-based risk contracts with health plans. The second work stream is provider network development which entails identifying participating providers and establishing the provider network, which may include the use of a Preferred Provider Network ("PPN") required under law and preferred by health plans. A critical component of this work stream is the development of an independent practice association ("IPA") affiliated with the health system. The third work stream is health plan engagement which involves close collaboration and contracting with health insurers.

PMH has begun to use its resources to commence CRC implementation efforts in Connecticut, including review of regulatory requirements, formation of an IPA entity, preliminary discussions with payors and evaluation of the care delivery network. PMH has formed an IPA called Prospect Provider Group CT-GWHN, LLC, which will be the IPA affiliated with the post transaction health system. PMH is currently developing the participation agreements for the IPA. PMH has also established a risk-taking entity called Prospect Health Services CT, Inc. Prospect Health Services CT, Inc. received its license to transact business as a PPN from the Connecticut Insurance Commissioner on October 21, 2015. PMH has also had preliminary discussions with

major payors in Connecticut to introduce the CRC model. PMH is optimistic that the discussions will result in most payors embracing the skills and expertise that PMH brings to the Connecticut market in its CRC model.

My remarks today will address how PMH's CRC business model will be beneficial to GWHN and supports the approval of the Application through (i) aligning physicians, hospitals, payors, community providers and all healthcare stakeholders; (ii) improving quality, (iii) improving efficiency, (iii) reducing costs, (iv) embracing health care reform, and (v) building comprehensive networks of care.

II. Community Benefits of the Transaction

Prospect's acquisition of GWHN will enable GWHN to remain an economically viable and vibrant part of the health care system in the cities and towns served by GWHN and is expected to provide many benefits to patients. First, GWHN will no longer have a third party debt service obligations. Therefore, GWHN will be in a better position to re-invest in its facilities and equipment.

Furthermore, GWHN will gain immediate access to PMH's experience and knowledge in implementing a population health management model that will prepare GWHN to accept value-based contracts with government and third party payers with the triple aim of improved patient care and experience, better patient health, and lower costs.

Finally, as discussed in Section VIII, below, through the implementation of the CRC model, GWHN will invest in both expansion of access and services to its surrounding communities.

III. CRC Aligns Physicians and Hospitals

The CRC model offers a critical benefit to the post transaction health system by fostering the alignment of physicians and hospitals. The CRC model utilizes meaningful collaboration of the medical staff and the community to provide better coordination of care. Along with the other hospital systems operated by PMH, Waterbury Hospital will realize many benefits from this physician/hospital alignment including increased physician involvement in governance, ability to accommodate various physician preferences for employment and affiliation, and ability to attract and retain physicians, including specialty physicians.

The alignment of physicians and hospitals under the CRC model includes physicians maintaining central roles in administration and overseeing the development of needed health services and oversight of the quality of care delivered to patients. In addition to stronger leadership and governance opportunities encouraged by the implementation of CRC, physicians will be supported with CRC care management programs to effectively manage patients' health needs.

The post transaction health system will benefit from PMH's status as a physician friendly company and, as part of the CRC model, PMH's aim to accommodate physicians' preferences for practicing medicine. PMH recognizances that some physicians prefer to be employed, some wish to remain independent but seek a hospital environment where independent physicians are valued, and others prefer to remain independent but work on a contracted or other basis in hospital-based clinics. PMH is able to provide the full range of options to physicians under the CRC model. As a result, PMH is able to attract and align both employed and independent physicians with the health system and the payor community. The CRC model is attractive for its physician alignment strategies, such as physician participation in an IPA or physician-hospital organization, hospital-based clinics staffed by independent contractor physicians, and opportunities to implement pay-

for-performance compensation arrangements which incentivize quality, patient satisfaction and better patient outcomes.

Additionally, the use of the CRC model improves PMH's ability to attract and retain physicians, including certain types of specialty physicians, to a community hospital setting that a community hospital may not be able to attract on its own. Under the guidance of the CRC model, PMH has been successful in recruiting physicians, including the most recent success in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners in Rhode Island, only 18 were previously employed by the CharterCare System prior to its acquisition by PMH. The CRC model brings significant value to physicians because of PMH's experience and success with risk-based payment arrangements that continue to expand and replace the fee-for-service payment system. By implementing risk-based payment arrangements, all providers are more aligned to improve quality and achieve better patient outcomes all while maintaining efficiencies and cost savings.

The CRC model has been highly successful in aligning physicians with PMH hospitals and improving quality and efficiency in California, and local versions of the model have been implemented in Texas and Rhode Island with similar success. PMH's historical achievement with the CRC model supports PMH's successful implementation in the Waterbury service area.

Because the CRC model emphasizes physician engagement and is adaptive to all forms of physician participation, the CRC model is poised to better align physicians with hospitals than the traditional models now in place. By achieving such alignment, PMH and the post-transaction hospitals will include physician governance and ability to accommodate various physician preferences, as well as attract and retain specialty physicians.

IV. CRC Improves Quality

The aim of the CRC model is to offer patients highly coordinated, personalized care so they can live healthier lives. As the CRC model is implemented in a health system, patients experience improved quality care.

CRC improves quality by utilizing disease and care management programs, ensuring availability of urgent care, and utilizing case management across the continuum. All of the programs will enhance quality at the post transaction health system. For example, PMH will employ the CRC model to create programs to identify patients with significant co-morbidities and then design comprehensive medical and psychosocial high intensity care management services for their care.

The CRC model also promotes quality by building and managing a tightly integrated, coordinated health care system. For example, physician integration between practices and facilities improves communication between providers, patients and institutions; creates universal best practices, standards and metrics; and improves patient access to ancillary services. PMH has received recognition for its quality. I refer you to page 80 of the Application for a summary of PMH's quality awards.

CRC improves quality because the model focuses on providing patients coordinated and personalized care to improve health. Enhanced quality of care is accomplished by utilizing health management programs, encouraging treatment at appropriate facilities and building integrated systems to improve care coordination.

V. CRC Improves Efficiency

The CRC model also promotes the efficient operation of hospitals and provider groups by aligning physician interests with the delivery of cost effective quality healthcare. One of the goals of CRC is to reduce the overall cost of healthcare by increasing preventative care and early interventions, reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. CRC promotes physician incentives and focuses on promoting coordination and establishing payor relationships that incentivize efficiency.

The implementation of CRC involves rewarding physicians for positive quality outcomes, not output, via shared savings and pay-for-performance standards and benchmarks. These CRC physician incentives have proved effective in Southern California, Texas and Rhode Island - PMH has demonstrated improved clinical outcomes, higher quality scores, higher patient satisfaction, lower re-admission rates, lower average lengths of stay, and lower medical-cost ratios. Bringing CRC to the post transaction health system will involve the implementation of successful CRC best practices regarding efficiency that have been established among its member hospitals to reduce readmissions. CRC also enhances efficiency through uniform productivity and financial management. PMH expects to see similar success in the GWHN service area with the implementation of CRC efficiency efforts.

CRC involves the utilization of resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace. In order to offer high value health care (and participate in the emerging value-based payment models to provide cost efficient care) CRC focuses on establishing new relationships among providers across the continuum of care. Essentially, the appropriate level of care must be provided at the right time by the correct provider. To achieve this, CRC methods include, but are not limited to: (i) development and management of

an advanced, comprehensive care continuum delivery network; (ii) population health management with the identification of those patients requiring high intensity care and sophisticated care management programs; (iii) actuarial and health economics data analytics; and (iv) integrated information technology.

Overall, the CRC model promotes efficiency through its development of a coordinated system and through physician incentives to utilize PMH's coordinated system in the most effective and efficient manner while keeping the focus on quality.

VI. CRC Embraces Health Care Reform Changes

Implementation of the CRC model allows a hospital or provider group to rebuild and retool itself for the new world of accountable health care delivery. The new model of health care is one that is evolving from federal mandates, changes in health care technology, patient demands, need for cost-containment, and evolving reimbursement models with are moving from volume to value, where providers will no longer be paid strictly on the volume of patients they treat, but on the value of the healthcare they provide. The CRC model offers flexibility to adjust to health care reform and the post-transaction system will benefit from the experience PMH has in implementing and running the CRC model.

Health care reform requires physicians, hospitals and other health care providers to work together, ensuring that all caregivers in a healthcare system align themselves with the patient's wellbeing as the focus. The post transaction health system, under the CRC model, will be able to continuously develop and adjust to new methods of reimbursement and savings due to flexibility built within the model that allows for various forms of provider integration. Because CRC embraces health care reform changes, opportunities to further integrate care delivery among providers and regionalize the health care delivery system in the Waterbury Hospital service area

will be realized. In line with health care reform, PMH has developed and implemented high intensity care management programs within its CRC model that integrate behavioral and physical health capabilities to effectively manage the care of patients with significant co-morbidities. The result is identification of patients at risk and building upon existing initiatives within GWHN's system.

Additionally, PMH's experience in implementing CRC will better enable GWHN to meet the health care reform requirements of the Patient Protection and Affordable Care Act. For example, PMH dedicates resources (and keeps an open dialogue with payors) to ensure that its CRC efforts are reflective and integrative of the latest payor programs. This allows hospitals and provider groups to quickly adjust to the changing healthcare delivery environment. PMH has thirty (30) years' experience operating provider groups, such as IPAs, and working with health care insurers and will bring that experience to GWHN. PMH also has invaluable experience through its operation of hospitals and medical management organizations which will be applied to the post transaction health system.

In sum, CRC embraces health care reform because the CRC model is adaptable to the changing health care environment and PMH management has the experience and ability that result in successful healthcare systems.

VII. CRC Reduces Costs

PMH does not anticipate any increase in costs to patients or insurers as a result of this transaction. PMH plans to assume GWHN's health plan contracts and through the implementation of CRC will add value and reduce costs. Implementing the CRC model requires the participation in evolving risk-based payment environment. As such, the CRC model will enable GWHN to be

successful with new risk-based payment systems and care delivery models that reward value-based care, achieving the best outcomes for patients at lower costs.

Health systems need to ensure efficient use of their assets to maintain a positive financial position and remain competitive. CRC achieves financial performance success by incentivizing physicians and patients to appropriately use urgent cares centers and to keep patients compliant with various homebound and other wellness programs. The result is keeping patients healthier while reducing the over-utilization of healthcare services. By utilizing appropriate care settings and resources, and managing chronic care patients, PMH avoids unnecessary, inefficient and duplicative services; and reduces medical errors which result in improved efficiency and cost savings. By implementing CRC in the post transaction health system, the cost of healthcare will be reduced for all healthcare stakeholders.

VIII. CRC Builds Comprehensive Care Networks

The application of CRC results in the establishment of comprehensive care networks. GWHN's implementation of the CRC model will provide a comprehensive care network by evaluating and promoting the management of care across a complete continuum in order to deliver services in the right place at the right time, aligning GWHN's physicians and other providers across this continuum of care, and developing integrated information systems.

As part of the CRC implementation process, PMH reviews the services offered by its systems and seeks to enhance or expand services. Such enhancements start with the development of primary care and specialty practices and the expansion of ambulatory offerings. These services provide more effective and resourceful alternatives to emergency room and hospital-based surgery. Further, CRC necessitates the management of patients with challenging chronic medical conditions, and keeps patients well in the appropriate care settings. By utilizing appropriate care

settings and resources and managing chronic care patients, PMH avoids unnecessary, inefficient and duplicative services and reduces medical errors which result in improved efficiency and cost savings.

The implementation of CRC will integrate and expand the GWHN's current network of providers and program offerings beyond what can be done currently by GWHN. Examples of development activities in Texas include: formation of a multi-specialty IPA; increasing behavioral health service capacity; expansion of hospital-based outpatient clinics; purchase of a rural hospital resulting in increased access to care; establishment of an emergency room; and leasing and converting additional space for expansion of services. In Rhode Island, PMH has accomplished the following: established an IPA with over 400 physicians, established a risk taking entity to accept delegation of health plan risk, purchased 28 primary care clinics, expanding access to care; joint ventured on a radiation-oncology center; expanded cardiac catheterization services, and worked closely with the Governor to launch a Medicaid pilot program. California is a mature market for PMH. More recent efforts to improve access to services in California include the following: purchasing a closed hospital in south Orange County (which PMH reopened in September 2015) to better serve patients who are members of PMH's owned or managed IPAs; and purchasing primary care and multi-specialty clinics to increase access to care. All of the above are examples of service line expansions and improving access to care. PMH will be able to achieve better care coordination of care for the GWHN community with the implementation of CRC.

CRC aligns GWHN's physicians and other providers across the continuum of care. The implementation of CRC improves the overall health of, and enhances the standard of care for, its patients. CRC encourages providers to be more clinically integrated with other care givers and enables patients to receive the right care, with the highest levels of quality, in the most appropriate

care setting. Through the development of the CRC and the attainment of these objectives, PMH will be successful in reducing unnecessary re-admissions, inpatient utilization, and emergency room visits which will translate into improved outcomes and lower health care costs for patients in the GWHN service area. For example, from 2012 to 2014 in California and Texas where PMH participates in HMO contracts for seniors, PMH has reduced hospital beds days per thousand from 1,260 to 720. Length of hospital stay for this population has been reduced from 5.1 days to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days have dropped from 19% to 13%.

Lastly, CRC involves the development of integrated information systems and best practices to ensure that patient care is coordinated across many levels of care. By introducing CRC, PMH provides access to its evidence-based practices aimed at improving quality and patient safety. In its development of the post transaction health system, PMH will partner with the medical staff to address gaps in care and services to ensure the effective management of all patients across the network.

When CRC is implemented across a health care system, it involves the review of the levels of care offered and the development of any gaps in care, the coordination and alignment of providers across the system and the development and utilization of integrated information systems and best practices. All result in better quality outcomes for patients in a cost effective delivery system.

IX. Conclusion

PMH's vision for Connecticut is to develop and maintain quality-driven hospitals with a robust network of aligned providers operating within its CRC platform. PMH's success in developing its CRC model comes by way of (i) aligning physicians and the hospitals, (ii)

improving quality, (iii) improving efficiency, (iii) reducing costs, (iv) embracing health care reform, and (v) building comprehensive care networks. The success of the CRC model in California, Texas and Rhode Island supports that there is a quantifiable benefit for implementing the CRC model in the GWHN service area. This proven success and projected success within GWHN from implementation of the CRC model supports the approval of the Application.

Thank you for your time and I welcome any questions.

PREFILE TESTIMONY OF
STEVEN ALEMAN

DEPARTMENT OF PUBLIC HEALTH	:	**DOCKET NO. 15-32017-486**
OFFICE OF HEALTH CARE ACCESS	:	
	:	
OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-02**
	:	
IN RE: GREATER WATERBURY HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**April 26, 2016**

PRE-FILED TESTIMONY OF STEVEN ALEMAN

I. Introduction

My name is Steve Aleman and I am the Chief Financial Officer of Prospect Medical Holdings, Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") and the proposed acquisition of assets of Greater Waterbury Health Network, Inc. ("GWHN"), including The Waterbury Hospital ("Waterbury Hospital"), by PMH. Specifically, I will address PMH's financial strength and the benefits of PMH financial resources to GWHN.

Professional Background

I currently hold the position of Chief Financial Officer for PMH. Since 2009, I have served in various capacities at PMH including Vice President of Corporate Development, Chief Financial Officer at Brotman Medical Center and Vice President Internal Audit at PMH. Prior to my employment at PMH, I was employed at Wellpoint Health Networks, Inc. ("Wellpoint") for ten years in various capacities. My last position at Wellpoint was Staff Vice President, Corporate Risk and Assurance. I am also a Certified Public Accountant.

Summary of PMH

PMH is a $1.3-billion-dollar healthcare services company that owns and operates fourteen (14) acute care and behavioral hospitals in Rhode Island, Texas, California and (with the closing of our transaction with East Orange General Hospital on March 1, 2016) New Jersey. In addition, PMH has executed a definitive agreement to purchase a hospital system in Pennsylvania. PMH maintains or is developing a robust network of specialty and primary care outpatient centers in each of its regions.

Long Term Debt to Equity Ratio

With respect to Exhibit Q5-1, page 1479, of the Second Set of Completeness Responses and the Long Term Debt to Equity ratio for PMH, the ratio's trend is positive as PMH consistently generated Net Income period over period thereby driving the negative equity balance (which had resulted from of dividend distributions) to positive as of FYTD 9/30/15. That growth in Net Income was a result of continued strong financial performance in both the Hospital and Medical Group segments. Ratios during this period fluctuate as negative equity decreases against fairly stable debt levels.

Summary of Financial Benefits

My remarks today will address how PMH's financial resources and industry know-how are beneficial to GWHN and support approval of the Application through (i) PMH's ability to fund the transaction and GWHN's debts and obligations; and (ii) improving the post-transaction health system's access to capital.

II. PMH Has the Financial Ability to Fund the Transaction

PMH has a proven record of financial success and is able to fund the transaction, allowing GWHN to fully satisfy its increasing debts and discharge its obligations as

outlined in the Asset Purchase Agreement ("APA"). This will allow future income generated from operations of the health system to be invested in equipment, technology, infrastructure, and expansion of health care services, rather than retirement of debt.

PMH is a $1.3 billion healthcare organization and has the financial capacity to provide the capital necessary for this transaction without the need to enter into transaction-specific financing arrangements. PMH has access to existing corporate level credit in addition to its cash on hand. There is no financing contingency with respect to this transaction. The Applicants anticipate that this acquisition (after giving effect for the assumption of liabilities), will be funded with its existing cash. PMH has agreed to and has the financial capacity to assume and fund certain of GWHN's debts and obligations; specifically, GWHN's pension liability. GWHN's portion of the unfunded pension liabilities with respect to its multi-employer defined benefit health plan (the Connecticut Health Care Associates Health Plan) are estimated to be at least $27,000,000 and are approximately $12,200,000 for the Cash Balance Plan. PMH's post-closing guarantee of these pension obligations adds substantial additional security to the participants of the pension plans beyond what currently exists with GWHN as a stand-alone entity, and assures that all current and former employees of GWHN will receive their full pension benefit.

In sum, PMH can fund the transaction without any associated risk.

III. PMH Improves GWHN's Access to Capital

PMH has access to capital that will make the necessary investments and improvements in GWHN possible. PMH's access to capital includes its favorable credit

lines and access to capital markets that will provide the necessary funding for GWHN's facilities.

PMH's access to capital includes a revolving line of credit with Morgan Stanley that has been preapproved and can fund the capital commitment amount in the APA. In order to draw on this line, PMH simply provides a 24-hour advance verbal notice to the lenders. PMH's excellent relationship with creditors will provide needed access to capital that GWHN does not currently maintain. This comes at a critical time as GWHN has experienced trouble obtaining financing and access to capital has impeded the expansion of programs and recruitment of providers. GWHN's capital needs are significant and necessary in order to recruit providers, offer the latest technology to be a competitive facility in the health care service area and perform needed physical plant renovations. Significant investments are also necessary for GWHN to develop new competencies and process skills and knowledge.

PMH has access to capital and will be investing the resources needed. PMH's access to capital markets that are not currently available to GWHN provides easier and quicker access to funding for replacements and upgrades to systems and infrastructure of the facilities. Capital needs at Waterbury Hospital are significant and cannot be met with current avenues available to GWHN for funding. Such investments include upgrades in technology in order to improve the collection and documentation of information and increase the availability of data for critical treatment decisions for patients; upgrades to the medical equipment and enhancements to provide patients access to state-of-the-art technology for their diagnosis, care and treatment; and program development to attract and retain physicians to the communities served. Without access to the capital that PMH will

provide, such provider recruitment, and facility upgrades and enhancement at GWHN will have to be delayed or even deferred. PMH's access to capital will provide the essential financial resources that GWHN has not been able to obtain on its own.

IV. Conclusion

In sum, PMH has a proven record of financial success and is able to fund the transaction as well as GWHN's increasing debts and obligations without placing the post-transaction health system at any unreasonable risk. PMH has access to capital that will help accomplish the needed investments and improvements in GWHN.

Thank you for your time and I welcome any questions.

PREFILE TESTIMONY OF
JONATHAN SPEES

DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 15-32017-486**
OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-02**
IN RE: GREATER WATERBURY HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**April 26, 2016**

PRE-FILED TESTIMONY OF JONATHAN SPEES

I. Introduction

My name is Jonathan Spees and I am the Senior Vice President of Mergers and Acquisitions at Prospect Medical Holdings, Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") and the proposed acquisition of assets of Greater Waterbury Health Network, Inc. ("GWHN"), including The Waterbury Hospital ("Waterbury Hospital"), by PMH. Specifically, I will address how PMH's financial resources and healthcare expertise will benefit GWHN.

Professional Background

I currently hold the position of Senior Vice President of Mergers and Acquisitions for PMH. Previously, I was Senior Vice President with The Camden Group, where I was a National Practice Leader for mergers, acquisitions and affiliations. Prior to The Camden Group, I was Chief Financial Officer for the University of Southern California's Keck Hospital of USC and USC Norris Cancer Hospital. I have also held positions as Senior Executive Vice President, Corporate Development and Finance, Founder of Merit Health Systems, LLC, a hospital management company, Managing Member of Abacus Ventures, LLC, and Managing Director of Shamrock Investments, LLC (both private investment and investment banking firms specializing in corporate

finance and mergers and acquisitions in the healthcare industry); Associate Director of Corporate Development for American Medical International; and audit manager and designated healthcare industry specialist for Deloitte Haskins + Sells, one of the eight largest public accounting firms worldwide at that time. I am also a Certified Public Accountant.

Summary of PMH

PMH is a $1.3 billion dollar healthcare services company that owns and operates fourteen (14) acute care and behavioral hospitals in Rhode Island, Texas, California and (with the closing of our transaction with East Orange General Hospital on March 1, 2016) New Jersey. In addition, PMH has executed a definitive agreement to purchase a hospital system in Pennsylvania. PMH maintains and is developing a robust network of specialty and primary care clinics in each of its regions.

East Orange General Hospital

PMH acquired East Orange General Hospital in New Jersey on March 1, 2016. The financial terms of that transaction are a purchase price of approximately $43 million dollars, including the assumption of liabilities; $6.5 million was ultimately used to fund the East Orange General Hospital Foundation. The amount and duration of the PMH capital commitment is $44 million over five (5) years. Funding for the approximately $23.5 million in cash required at the closing was from a drawdown of PMH's revolving credit facility.

Crozer-Keystone Health System

PMH has entered into an agreement to buy Crozer-Keystone Health System ("CKHS") in Pennsylvania. The financial terms of the transaction are confidential but include a $200 million capital investment in the medical centers over the next five (5) years and the assumption of the pension liability currently estimated at approximately $120 million. The PMH CKHS transaction

requires PMH to keep open all licensed hospitals, including any campuses of a licensed hospital where inpatient acute care services are provided. CKHS has only two licensed hospitals, currently operating on five campuses. PMH's plan to fund the purchase price, capital commitment and pension liabilities is by increasing its corporate credit facilities and through funds generated from future operations of PMH, including CKHS. The transaction is currently undergoing regulatory review by the Attorney General of the State of Pennsylvania. A public hearing is scheduled for May 4, 2016 and PMH anticipates closing the transaction on or about June 30, 2016. Acquisition of CKHS is anticipated to have a positive impact on PMH's ability to meet its financial commitments in connection with the proposed GWHN and ECHN asset purchases by increasing our cash generated from operations and future ability to access the capital markets as needed.

Summary of Financial Benefits

My remarks today will address how PMH's financial resources and industry know-how are beneficial to GWHN and support approval of the Application through (i) putting the post-transaction health system in a positive financial position; (ii) adding stability to the Connecticut healthcare community; and (iii) allowing the post-transaction health system to build a comprehensive network of care.

II. PMH Will Put GWHN in a Positive Financial Position

PMH has successfully restored the financial position of many health systems by applying its data-driven, disciplined operating strategies, leveraging its corporate capabilities, and investing in growth. GWHN, like many community health networks, has experienced financial difficulties and has been seeking an affiliation with a larger, well-capitalized healthcare system for several years. GWHN has long standing financial challenges which began prior to 2005 with years of financial losses and that continue to this day. GWHN is in financial distress, has aged facilities

and lacks access to capital. Even after the execution of the Letter of Intent between PMH and GWHN, GWHN's liquidity and financial performance deteriorated. With the proposed asset purchase, PMH will provide sufficient capital to meet deferred, current and future capital needs for the Hospital's physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology. Prospect's capital and access to capital will mean that GWHN will have the financial resources to purchase new technology, upgrade its facilities, attract skilled providers, and upgrade electronic health records, in addition to investing in service line development, physician alignment and recruitment and development of increasing ambulatory access. PMH has also agreed to fully assume the pension benefit plans of the GWHN employees.

III. Financial Security Offered by PMH Provides Stability and Support for the Needs of the Community and its Access to Health Care

The financial security that PMH will bring to the post-transaction health system will resonate through the community. Our investment in developing GWHN's delivery network will allow patients to receive their care locally as opposed to facilities owned by competitors in Hartford and other communities outside Waterbury. A positive financial position and growth of GWHN's delivery network will allow the post-transaction health system to offer continued levels of employment that are critical to the local economy. Waterbury Hospital is a large employer in its market and, as such, the financial success of the hospital leads to a more financially secure community.

Prospect has agreed to operate Waterbury Hospital as an acute care hospital. The hospital will have a local advisory board that will permit continued community involvement in operations. Additionally, PMH has agreed to maintain and adhere to GWHN's current policies regarding charity care and indigent care, or adopt other policies that are at least as favorable to the community

as GWHN's current policies – which are generally comparable to charity care policies at PMH's other hospitals (as determined by local leadership at the hospital). PMH's ability to successfully operate the post-transaction health system and thus continue to offer charity care at current levels provides a positive community benefit for indigent and needy populations in the service area. Furthermore, PMH's Coordinated Regional Care model of population health management and preventative medicine will result in more access to outpatient care.

Regarding PMH's history of community benefit, a number of PMH hospitals are "safety-net hospitals." In fact, PMH is a member of Private Essential Access Community Hospitals ("PEACH"). PEACH is a network of private, core safety net hospitals in California that care for disproportionate share or low income, medically vulnerable patients. PMH intends to bring this spirit of community support and benefit to The Waterbury Hospital.

Further, the financial security offered by PMH results in the continued support of community building activities in the Waterbury area. In accordance with the provisions of the Asset Purchase Agreement ("APA"), PMH will commit to spend within seven (7) years of the closing not less than $55,000,000 (less the amount not to exceed $3,500,000 of Capital Lease Obligations assumed by Buyer at Closing in excess of $3,000,000) in capital for the benefit of the health system. These expenditures may include: (i) capital projects, including routine and non-routine capital expenditures, at, or for the benefit of, the hospital businesses and/or the acquisition, development and improvement of hospital, ambulatory or other health care services in the greater Waterbury, Connecticut community, which shall include, for the avoidance of doubt, expenditures relating to the implementation of PMH's coordinated regional care model ("CRC") and physician recruitment. PMH's investments in the post-transaction health system provide financial security

and support to the community by way of continued employment, facility upgrades, an expanded and aligned physician network and improved ambulatory access.

Because GWHN's cash reserves have declined in the past year, and in order to assure that there is adequate cash available at closing of the proposed transaction to pay off GWHN's secured debt, PMH has agreed to make two significant changes to the draft APA which was included in the initial CON filing:

1. To provide that the calculation of the Purchase Price pursuant to Section 2.05 will not be less than zero;
2. To eliminate the Indemnification Holdback Amount ($4,500,000).

If PMH assumes liabilities pursuant to #1, or incurs unreimbursed post-closing indemnification claims (because there is no Holdback) pursuant to #2, the capital commitment can be reduced, but not by more than $9,500,000. Based on current estimates, the capital commitment would be reduced by approximately $2,000,000; however, this figure is subject to change based on GWHN's operating results from March 31 to the closing and if there are any post-closing amounts due from GWHN to PMH. Changes to the Letter of Intent and the APA are currently being drafted and will be filed when complete.

IV. PMH's Financial Resources Will Aid the Post-Transaction Health System in Building Comprehensive Networks of Care

PMH's financial position will enable the post-transaction health system to have access to resources for the purpose of integrating and expanding the network of providers and program offerings beyond what exists today. Fostering an environment that aligns physicians and other providers across the continuum of care provides access to evidence-based practices to improve quality and patient safety, enhances efficiency through uniform productivity and financial

management, and develops integrated information systems. PMH has access to the financial resources required to develop stronger integration with provider affiliates to coordinate care, create new access points by expanding outpatient services, improve the overall population health and enhance the standard of care for its patients. Our care model actually lowers overall healthcare costs by keeping people healthy, providing care more efficiently, reducing unnecessary hospitalizations, and providing needed care in the right setting at the right time. My colleague, Dr. Mitchell Lew, will discuss in detail PMH's Coordinated Regional Care model which, when successfully implemented, lowers the overall cost of healthcare for consumers, insurers and government payers versus traditional fee-for-service models.

Stand-alone providers have special challenges containing costs while delivering quality care. Without the appropriate financial resources that a national system provides, independent providers struggle to be both effective and efficient. GWHN has had difficulty recruiting and retaining providers to GWHN's service area and has suffered while its competitors both locally and from Hartford and Danbury have hired its physicians and developed ambulatory facilities which benefit communities other than Waterbury. PMH has the financial ability to make the necessary investments in infrastructure and personnel to establish the continuum of care needed to develop a highly integrated and successful health system.

V. Community Health Needs Assessment.

PMH specializes in building comprehensive networks of quality healthcare services designed to meet the needs of the communities it serves. PMH's goal is to best serve the healthcare needs of both the communities in which PMH currently operates and of the communities in other states like Connecticut where PMH seeks to grow.

The performance of a Community Health Needs Assessment ("CHNA") is a requirement for tax-exempt hospitals in order to maintain this tax status or designation. The performance of a CHNA does not guarantee that identified community needs will be met by a tax-exempt hospital. PMH is not seeking to continue the tax exempt status of any of the entities in the GWHN transaction nor does the GWHN transaction involve a tax exempt joint venture partner. It should be noted that PMH has never been required to conduct a formal Community Health Needs Assessment post-conversion or acquisition of a nonprofit hospital. Although PMH is not tax exempt and therefore not required to engage in a CHNA, PMH recognizes that reputation in the community and thus its long term success depends on meaningfully investing in and providing needed care to the communities it serves. PMH is constantly identifying and developing resources to serve current and future healthcare needs in the communities it serves. PMH strives to improve and strengthen programs and services it provides. Furthermore, PMH's focus on preventative medicine and population health management improves access and enables PMH's hospitals to address the health needs of its communities. As stated above, PMH focuses on building comprehensive networks of care that address the community's needs.

PMH, and more importantly, our local management teams, work closely with their Local Boards to assess and determine the community health needs of the population served and how to best implement programs to address these needs. The use of the Local Board allows for wide-spread public input and collaboration with other health care providers in the community. It is PMH's intention to involve the Local Board in assessment processes as a way to facilitate public input and to publicly disseminate, via the website or other means, final assessments and implementation plans.

VI. Conclusion

The approval of the conversion application and proposed transaction will (i) put GWHN in a positive financial position; (ii) allow PMH's investments in the post-transaction health system to provide financial security and support to the community, and (iii) enable the post-transaction health system to have access to resources for the purpose of integrating and expanding the network of providers and program offerings beyond what exists today.

Thank you for your time and I welcome any questions.

RESPONSE TO ISSUES IDENTIFIED IN HEARING NOTICE

Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("Prospect" or "PMH") (GWHN and Prospect are referred to collectively as the "Applicants") submit the following responses to the Issues requested by the Office of the Attorney General and Office of Health Care Access on April 13, 2016.

1. **With respect to PMH's recent acquisition of East Orange General Hospital in New Jersey, please describe the financial terms of that transaction, including without limitation, the purchase price and amount and duration of any capital commitments. Please also describe the funding sources used by PMH to pay the purchase price and those that will be used to fund any capital commitments or other material financial obligations of PMH at East Orange General Hospital.**

Response:

PMH acquired East Orange General Hospital in New Jersey on March 1, 2016. The financial terms of that transaction are a purchase price of approximately $43 million dollars, including assuming liabilities, $6.5 million of which was will be contributed to the East Orange General Hospital Foundation. The amount and duration of the capital commitment is $44 million over five (5) years. The funding for the approximately $23.5 million in cash required at the Closing was from a drawdown of PMH's revolving credit facility.

2. **PMH has entered into an agreement to buy Crozer-Keystone Health System in Pennsylvania. Under the reported terms of the agreement, PMH is pledging to keep all five Crozer-Keystone hospitals open and invest $200 million in the medical centers over the next five years in capital commitments as well as assuming Crozer-Keystone's outstanding pension liability of $100 million. Please provide an update on the status of this proposed acquisition addressing, in particular:**

    a. **the financial terms of the transaction;**

    b. **PMH's plan to fund the purchase price, capital commitment, pension liabilities and other material financial obligations associated with the transaction;**

    c. **the status of any necessary governmental or non-governmental approvals connected with the transaction;**

    d. **the anticipated closing date; and**

    e. **the impact that the transaction will have on PMH's ability to meet its financial commitments in connection with the proposed GWHN and ECHN asset purchases in Connecticut.**

Response:

Please note the PMH Crozer-Keystone transaction requires PMH to keep open all licensed hospitals, including any campuses of a licensed hospital where inpatient acute care services are provided. Crozer-Keystone has only two licensed hospitals, currently operating on five campuses.

PMH has entered into an agreement to buy Crozer-Keystone Health System ("CKHS") in Pennsylvania. The financial terms of the transaction are confidential but include a $200 million capital investment in the medical centers over the next five (5) years and the assumption of the pension liability currently estimated at approximately $120 million. PMH's plan to fund the purchase price, capital commitment and pension liabilities is by increasing its corporate credit facilities and through funds generated from future operations of PMH, including CKHS. The transaction is currently subject to regulatory review by the Attorney General of the State of Pennsylvania. A public hearing is scheduled for May 4, 2016 and we anticipate closing of the transaction on or about June 30, 2016. Acquisition of the Crozer-Keystone Health System is anticipated to have a positive impact on PMH's ability to meet is financial commitments in connection with the proposed GWHN and ECHN asset purchases by increasing our cash generated from operations and future ability to access the capital markets as needed.

3. **With respect to the surveys of PMH's Southern California Hospitals completed on 4/21/14, 8/21/14, 9/25/15 and 12/22/15 as well as the survey of Los Angeles Community Hospital ("LACH") completed on 11/10/15 that resulted in the California Department of Health declaring Immediate Jeopardy situations to exist, please identify when GWHN first learned of each Immediate Jeopardy determination. Please also discuss GWHN's due diligence after having learned about the Immediate Jeopardy determinations and the conclusions based upon that due diligence.**

Response:

PMH's quality issues in the California hospitals became known when they were disclosed to GWHN as part of Prospect's response to the ECHN completeness questions in late 2015 and OHCA/AG asked GWHN about these issues in its completeness questions to GWHN in January 2016. In early February 2016, PMH initiated several calls with WH's management team and counsel to detail the CMS deficiencies at Culver City and Los Angeles Community Hospitals, and its plans for investigation and remediation.

These quality issues were reported to the WH Board in Executive Session on February 11, 2016. In response, GWHN's Board Chair appointed a task force ("Task Force") comprised of four Trustees who are physicians, the Medical Director of Performance Improvement, the Chief Nursing Officer and the Director of Performance Improvement. The appointees all had significant expertise in the areas of regulatory surveys, CMS Conditions of Participation and hospital quality standards. The goal of the investigation was to review the materials and undertake such diligence that they believed appropriate and report their findings back to the Board together with a recommendation about whether to proceed with the transaction.

To accomplish this goal, the Task Force requested, received and reviewed extensive amounts of information from PMH, including past regulatory surveys for its hospitals in California, Texas and Rhode Island, its corrective efforts in those hospitals, and its year over year quality metrics and documentation of the quality improvement programs for those hospitals. The Task Force focused in particular on the surveys of PMH's California hospitals dealing with Immediate Jeopardy findings.

In addition to these investigatory efforts, the GWHN quality review team requested, and PMH made available, members of PMH's management to be interviewed. They provided extensive detail on the root causes of the Immediate Jeopardy issues in California and the remediation efforts that had been completed or were actively under way to address those issues. A number of meetings were held.

In addition to a lengthy study of the CMS Survey results and interviews, with senior PMH members, GWHN team made site visits to California and Rhode Island. GWHN's President/CEO and Chief Operating Officer and the Vice President of Alliance Medical Group travelled to California and visited Los Angeles Community Hospital, Culver City, and interviewed the senior team onsite. The Task Force gave special attention to the experiences of PMH's CharterCARE hospitals, Roger Williams Hospital and Our Lady of Fatima Hospital, both of which are located in Providence, Rhode Island, and thus are the closest to GWHN geographically. The GWHN reviewers found not only that the CharterCARE programs were of high quality, but that they had been enhanced in notable, positive ways rather than cut back after PMH's acquisition.

The Task Force presented its report and recommendations to the Board of Directors on April 14, 2016. There was a thorough question and answer session and an examination of the recommendations. The Task Force recommended that GWHN seek written assurances from PMH about the continuation of certain quality programs and the prospective obligation to undertake other actions. The Task Force recommended that GWHN seek a commitment from PMH that GWHN's patient quality, patient experience and safety programs be maintained, and if possible, be improved. PMH has agreed to continue GWHN's patient quality, patient experience and safety programs and also to facilitate collaboration with other PMH hospitals, including allowing GWHN to benefit from sharing best practices among the Prospect hospitals in the northeast and nationally. Based on the information learned and the protections gained from this additional commitment from PMH, the task force recommended, and the Board confirmed, GWHN's commitment to proceed with the transaction.

4. **Please provide an update on the status of any subsequent surveys and findings of the CDOH with respect to the Statement of Deficiencies issues in connection with the 12/22/15 of Southern California Hospital at Culver City and the March 23, 2016 letter to LACH informing LACH that it continues to be out of compliance with respect to the CMS Conditions of Participation for hospitals in the areas of Nursing Services and Infection Control.**

Response:

Southern California Hospital at Hollywood:

The credible allegation of compliance was submitted on March 22, 2016 related to the CMS full validation Survey that was conducted on December 18th – 22nd, 2015.

The Resurvey by CMS was conducted on April 4th – 8th, 2016.

We are awaiting the CMS results.

Los Angeles Community Hospital:

The Hospital submitted its credible allegation of compliance regarding the deficiencies identified in the CMS Correspondence dated March 23rd, 2016 on April 7th 2016.

CMS is in the process of conducting their survey based upon the April 7th 2016 plan of correction the week of April 25th, 2016.

5. **In the Application at page 84, PMH has committed to continue to provide financial support for community building activities in the Waterbury area. Particular community services and benefits currently provided by Waterbury Hospital, such as the Food for Life Program, are possible via funding through state, federal, or private grants. Please describe the extent to which GWHN has explored its ability to keep these programs grant funded if Waterbury Hospital is converted to for profit status and any role the Independent Foundation being formed as a part of this proposal might play in sustaining any grant-funded activities.**

Response:

GWHN has reviewed every grant and identified which could continue to flow to a for profit entity, and identify which could not. In the event the grant could not continue to flow to a for profit hospital, GWHN has made or is in the process of making alternative plans to ensure the continuation of services that are being provided to members of our community.

Most notable is the Ryan White grant which serves 700 HIV clients. Many hours of research and negotiations have gone into ensuring the future viability of this important community service. This HRSA grant cannot flow to a for profit entity. GWHN has entered into an agreement with the nonprofit Staywell Community Health Center which will serve as the fiscal agent, and become director of this clinic. Staywell will then buy services from the post closing hospital and its affiliates to ensure the patient/caregiver relationship not be disrupted. The Ryan White Clinic at Waterbury Hospital is an important community service and we are very pleased with the resolution. It is through these grant dollars that the Food for Life Program allows HIV patients access to fresh produce at the Brass City Harvest farmers market which is open to the public at Waterbury Hospital every Friday.

Bridge to Success: As an active participant in the community-wide Bridge to Success program, GWHN provides classes and support to students and their parents on a wide range of topics. The Summer Bridge program provides onsite education to at risk youth to prepare them to take the SAT. Many of the children start this program in the sixth grade and continue through high school. Additionally, the hospital provides Parents' Leadership Institute and Children's Leadership Institute in English, Spanish and Albanian. These courses help students become advocates for themselves, for their communities and for their families. The source of funding for these courses may be at risk. Therefore, GWHN has come to an agreement with Naugatuck Valley Community College to become the sponsor of these important courses that will continue to meet on the Waterbury Hospital campus.

Finally, the Childcare Center of the Greater Waterbury Health Network is not part of the proposed transaction. To ensure its long term viability, GWHN is currently in discussion with two potential nonprofit organizations that may be able to bring the center into their operations with little to no disruption. A recommendation is forthcoming from the Childcare Center board.

Several grants will continue to flow directly to post closing Waterbury Hospital.

The new Independent Foundation may have fund raising activities in the future and that Independent Foundation will determine where its funds best be used.

6. **With respect to page 1465 of Applicants' February 16, 2016 responses to completeness questions (the "Second Set of Completeness Responses"), please elaborate on the specific circumstances that contributed to the declines in inpatient and outpatient surgical cases between FY 14 and FY 15 and the overall decline in total outpatient cases over the same period which led to a deficit in revenues over expenses of $21,995,334 in FY 15 --a deficit increase of approximately $15.7 million for Waterbury Hospital over the prior fiscal year. In addition, please discuss the current profitability of Waterbury Hospital and how the Applicants intend to address these declines in volume and net patient service revenue post-closing.**

Response:

OUTPATIENT SURGERY DECLINE. Following the termination of the Tenet deal in December of 2014, there was significant uncertainty about the future of health care in the greater Waterbury area. In reaction to this uncertainty, several Waterbury Hospital affiliated surgeons bought into a physician-owned outpatient surgery facility in Southington in January of 2015. In addition, Saint Mary's Hospital bought one of the two GI practices in Waterbury and shifted all of their business to Saint Mary's causing a decline in the GI cases at Waterbury Hospital. Year over year, all surgical cases at Waterbury Hospital fell 9.87% while outpatient surgery fell 10.5%.

OVERALL OUTPATIENT BUSINESS DECLINE. Emergency room visits fell by 3,053 (5.69%); specifically, ED cases "seen and discharged" were down 3,266 (7.46%). This decline is primarily due to the increase of walk-in /urgent care business in the area. Overall outpatient volume (excluding ED) was down 7.1%.

CURRENT PROFITABILITY OF GWHN AND THE HOSPITAL. As the losses mounted in FY 2015, the Hospital contracted with The Camden Group to conduct an assessment of operations and recommend potential areas to reduce costs. In addition, the Hospital negotiated increases in managed care contracts, became eligible for additional Medicare revenue through an increase in the Medicare wage index due to being reclassified from New Haven Country to Nassau County in New York with all New Haven County hospitals, and implemented numerous cost savings measures (see chart below). The total of all initiatives is $26.2M. These initiatives have resulted in improvement. Through March 31, 2016 (6 months of operations), the overall Network has net income of $834,583, while the Hospital has net income of $5,623,041.

2016 Economic Improvements Budgeted

Specific Examples	Revenue Initiatives	Expense Initiatives
Medicare Inpatient	$4,900,000	
Medicare Outpatient	869,000	
Managed Care Contracts	3,600,000	
Elimination of 403b match		560,133
Reduced salaries (5, 7, 10, 20%)		3,446,494
Materials Management Improvement		575,000
All other items		12,264,532
Totals	**9,369,000**	**16,846,159**

GWHN continues to monitor all initiatives replacing ideas that were not successful with new initiatives as the year evolves.

7. **With respect to Exhibit Q5-1, page 1479, of the Second Set of Completeness Responses and the Long Term Debt to Equity ratio for PMH:**

   a. **Please explain the ratio's downward trend from a negative 37.0 in FYTD 7/31/14 to an even higher negative ratio of 349.8 in FYTD 9/30/14; and**

   b. **elaborate on the steps or initiatives taken that contributed to the ratio's increase between FYTD 9/30/14 and FYTD 9/30/15 from a negative 349.8 to a positive 11.6.**

Response:

Please note that the referenced trend is not downward and merely a mathematical result of reduced negative equity against a relatively stable debt total.

Negative equity occurred as a result of dividend issuances in years prior. Equity moved from <$11,410>, to <$1,206> to positive $36,440 as a result of positive net income during the measurement periods.

The positive net income trend was primarily due to improved performance in the Hospital and Medical Group Segment business and financial operations.

8. **In reference to the Financial Worksheets submitted as Exhibit Q6a-1 to the Second Set of Completeness Responses, please explain the zero incremental gains/losses associated with this proposal for GWHN when in Applicants' initial October 28, 2015 submission, pps. 1167-68, a Financial Worksheet for GWHN was submitted that included incremental amounts associated with this proposal.**

Response:

When the response was submitted in the second round of completeness questions, we submitted the information as GWHN only without the incremental with CON which is what we thought was the proper response. The incremental revenue included in the original filing is still accurate.

9. **Provide annual cash flow that would be generated and become available to support capital projects over the next five years at Waterbury Hospital as a result of PMH's addressing GWHN's debt and pension obligations.**

Response:

No change is anticipated in cash flow related to PMH's assumption of the GWHN pension obligations. Repayment of the GWHN secured debt as of the Closing will eliminate approximately $1.6 million of annual debt service payments, which will allow future income generated from GWHN operations to be invested in capital and growth, rather than retirement of debt.

10. **Please provide a list of critical, immediate (over next 2-3 years) capital needs at The Waterbury Hospital.**

Response:

Immediate Capital Needs: First two – three years

Patient Safety – Critical – In Order

1.	Monitors in ER	$600,000
2.	ER architects/plan	$200,000
3.	Nuclear Med	$450,000
4.	Fetal Monitors	$145,000
5.	EKG	$550,000
6.	Defibrillators	$240,000
7.	Jackson tables (2)	$200,000
8.	Nurse Call/ED	$220,000
9.	Bed replacements	$360,000
10.	Med Cart Replacements	$150,000
11.	Begin anesthesia update	$120,000
TOTAL		**$3.235 million**

Patient Safety – Second Tier

1. Bed replacements
2. Complete anesthesia
3. Cardiac stress
4. Isolettes
5. GI equipment
6. OR bed replacements
7. Digital radiology
8. Mobile digital radiology
9. Patient monitors/Reed
10. OR lights
11. Med cart replacements

OTHER [1]

ER- radiology bldg. project

Hybrid interventional room

Outpatient site 1

Maternity Department upgrade

Outpatient surgery center

Outpatient site 2

[1] The capital needs described above have not been reviewed by PMH, other than at a high level. Although such capital needs appear reasonable, final allocation of the capital commitment will be made post-closing based on PMH's strategic and capital planning process and considering the overall needs of the community, its population health, the delivery network, the GWHN facilities, and other relevant factors.

11. Please provide a complete description of the Local Board, including, but not limited to, its composition, the process for appointment and replacement of members of the Local Board, and how it will function regarding oversight of quality assurance in conjunction with the Hospital Board and PMH's corporate quality team.

Response:

The Local Advisory Board is to be formed by PMH and composed of 9-12 members. The Chief of the Medical Staff and the Head of Clinical Quality will serve as *ex officio* members. A member of the Board of Director of the local Prospect affiliate will serve on the Local Board, too. The composition of the Local Advisory Board will be diverse, taking into account, work and life experience, gender, sexual orientation, age, cultural, economic, ethnic, religious and racial background, residency and other factors.

The Advisory Board's duties are outlined in the Asset Purchase Agreement.

The Asset Purchase Agreement provides that the Local Board will:

> .....(i) make recommendations and suggestions to Buyer regarding the mission, vision and value statements with respect to the Hospital and the Hospital Businesses; (ii) make recommendations and suggestions with respect to medical staff credentialing, disciplinary action of staff physicians, and compliance with accreditation requirements; (iii) provide input on policies and clinical programs; (iv) provide input in the development and review of strategic plans; (v) provide input on operating and capital budgets; (vi) provide input and support physician recruitment efforts; (vii) provide input on succession plans for executive leadership at the Hospital; (viii) promote community health initiatives, fostering community relationships and identifying service and education opportunities; and (ix) monitor the commitment to maintain and improve quality indicators. [Section 6.12]
>
> .....work together with the Local Board and medical staff of the Hospital to preserve the existing staff membership and the current privileges of each physician, as well as the medical staff leadership. [Section 6.14]

A description of the Corporate Quality Program, including an organizational chart, provides an overview regarding how quality assurance will function in conjunction with the Hospital Board and PMH's corporate quality team. Pursuant to a Quality Assurance Agreement (provided under separate cover), PMH has agreed to maintain the respective quality program and goals of Waterbury Hospital for a period following the transaction. PMH is also committed to provide the necessary staff to support such quality programs. In addition, PMH agrees to share the best practices at its other facilities with Waterbury Hospital.

PRESENTATIONS FOR MAY 3, 2016 HEARING

THE PROPOSED TRANSFER OF ASSETS OF GREATER WATERBURY HEALTH NETWORK TO PROSPECT MEDICAL HOLDINGS

Presented to the Office of the Attorney General and the Department of Public Health's Office of Health Care Access

May 3, 2016

01644

Greater Waterbury Health Network

Proposed transaction:
Prospect Medical Holdings buys GWHN assets

- **Overview of our Process**
  - Carl Contadini, Chairman, Board of Directors, Greater Waterbury Health Network
- **GWHN Today and Future Plans**
  - Darlene Stromstad, FACHE, President/CEO, Greater Waterbury Health Network
  - Susan Cordeau, BS, RN, Director, Performance Improvement, Waterbury Hospital
- **Medical Staff Involvement**
  - Carl Sherter, MD, Former Chief of Staff, Member of GWHN Board Transaction Committee
- **Representatives from Prospect Medical Holdings**

Greater Waterbury Health Network

OVERVIEW OF OUR PROCESS

Carl Contadini, Chairman, Board of Directors
Greater Waterbury Health Network

01646

Greater Waterbury Health Network

Long journey

GWHN Board began reviewing options for sustaining the organization more than 10 years ago

- 2005: Commissioned study on merger with Saint Mary's Hospital (SMH)
- 2006-07: Discussions between GWHN & SMH
- 2007: Draft OHCA report recommends consolidation of two hospitals
- 2008: Unable to reach agreement, discussions end

Sense of urgency

- 2009: GWHN defaults on CHEFA bond covenants
- 2010: Board engaged consultants to analyze projected capital needs; anticipated cash would be depleted by 2015
- 2011: Board forms task force to chart future course of GWHN; new CEO hired
- 2011: Investment advisors – Cain Brothers – selected to lead process to cast net for potential partners
  - Priority was sustainable, high quality, accessible healthcare

Greater Waterbury Health Network

Proposed venture: LHP, GWHN & SMH

- 2011: Two finalists selected – Vanguard Health and LHP
- 8/2011: LHP, which had an LOI with SMH, was selected based on its promise to build a new hospital
- 2011-12: Work continues on merger of two Waterbury hospitals
- 8/2012: LHP terminates relationship with both hospitals; leaves Connecticut

Greater Waterbury Health Network

And the next chapter

- 8/2012: GWHN task force regroups, meets with SMH to explore any possibility to work together
  No path forward identified
- Fall 2012: Task force again goes back into market; reaffirms priority to provide sustainable, high quality, accessible healthcare with a commitment to invest in outpatient service strategy, physician recruitment, capital upgrades
- Fall 2012: Two finalists interviewed – Vanguard Health and Prospect Medical Holdings
- 10/2012: Vanguard Health selected

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Greater Waterbury Health Network

Process continues

- August 2013: Vanguard announces strategic alliance with Yale New Haven Health System
- October 2013: Tenet Healthcare purchases Vanguard
- July 2014: Tenet announces inclusion of SMH in deal (two separate hospitals in Waterbury under one parent company)
- October 2014: GWHN public hearing held
- November 2014: Transaction approved with over 70 conditions
- December 2014: Tenet announces departure from CT
- January 2015: In spite of political overtures, Tenet departure final

New strategy & Prospect Medical Holdings

- ***GWHN defines two-part strategy:***
  - ***rebuild the organization***
  - ***simultaneously identify potential partners***

- Spring 2015: Limited pool of potential partners
- 5/2015: LOI with Prospect Medical Holdings announced
- 8/2015: GWHN holds first public hearing
- 12/2015: GWHN enters into a forbearance arrangement with its bondholder

Greater Waterbury Health Network

Overview of transaction

- **Approximately $45 million purchase price, subject to certain adjustments**

  (cash, assumption of certain liabilities, such as pension)

- **Approximately $55 million capital commitment, subject to certain adjustments**
  - Facility improvement
  - Equipment updates
  - Development of Coordinated Regional Care model

Greater Waterbury Health Network

Overview of transaction

- **Included** — Substantially all assets including hospital, physician practices, joint ventures, real estate
- **Excluded** — Restricted funds, charitable assets, child care center, captive insurance company, inactive entities, certain liabilities

Greater Waterbury Health Network

Overview of transaction

Prospect Medical Holdings, Inc. to buy substantially all assets of GWHN

- Continued operation of Waterbury Hospital
- Continued involvement of an advisory board that includes community representatives
- Capital investments to improve facilities and equipment and physician recruitment and network
- Hire all employees and assume contracts
- Continuation of charity care and indigent care
- Establishment of community foundation to oversee certain charitable funds

Greater Waterbury Health Network

The Community Foundation

- A new, totally independent foundation will be formed
- Hold or receive the benefit of certain charitable assets
- Receive net proceeds of sale
- No post-closing liabilities

Greater Waterbury Health Network

GWHN TODAY & FUTURE PLANS

Darlene Stromstad, FACHE

President/CEO, Greater Waterbury Health Network

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Greater Waterbury Health Network

2015: Implications of Tenet's Departure

- Organization had suffered deeply from the departure of Tenet
- Employees left
- Physicians changed allegiances, some invested in competitive surgery centers
- Dual challenge of running a high quality hospital with decreasing funds and working on a new deal

Focused goals

- **Chose Prospect for several reasons:**
  - Understand the regulatory environment of the Northeast
  - Address immediate needs while making a long-term commitment for growth
  - Offer least disruption to our services and employees
  - Had experience in new models of healthcare payment and delivery
  - Successful in Rhode Island

Greater Waterbury Health Network

Aligned mission

- Industry dramatically changing, moving from fee-for-service to value-based
- Reimbursement changing – and it is not getting any easier
- Enormous pressure on hospitals like ours
  – simultaneously addressing financial stresses while adapting to a new payment and delivery system

Greater Waterbury Health Network

- The Waterbury Hospital
- VNA Health at Home
- Greater Waterbury Management Resources
- Greater Waterbury Health Services
- Alliance Medical Group
- Cardiology Associates of Greater Waterbury
- Access Rehab Centers
- Imaging Partners
- Waterbury Gastroenterological Co-Management
- Harold Leever Cancer Center
- Heart Center of Greater Waterbury
- Greater Waterbury Imaging Center
- Valley Imaging Partners

Who We Serve

- 12,000 people are treated at Waterbury Hospital as inpatients
- 180,000 individuals are treated on an outpatient basis
- 54,000 visits are made to the Emergency Department
- 134,000 visits are made to our employed, community physicians
- 2,300 patients are cared for by VNA Health at Home
- 150,000 patients are treated at Access Rehab Centers
- Region's most comprehensive behavioral health services
- Comprehensive HIV/AIDS program, with largest HIV primary care clinic in Northwest Connecticut, serving over 450 patients annually

Greater Waterbury Health Network

- Financially and operationally stable
- No access to capital to be competitive and sustainable
- Proud history – 126 years – of providing world class, high quality healthcare in a teaching environment
- Care for some of the state's most at-risk population; ***and are proud to be their advocate***

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Greater Waterbury Health Network

Prospect partnership

- Strong medical staff partner
  - IPA already has 300 plus members
- Long history of population health management
  - discussions with health plans underway
- Access to capital
  - plans underway for capital projects and upgrades

Our relationship with Prospect

- **Prospect meets our original goals of:**
  - **Sustainability**
    - Access to capital, in this for the long-haul, experienced healthcare company, demonstrated commitment to the Northeast
  - **Accessibility**
    - Charity care, continuation of services, physician recruitment, outpatient service development
  - **High quality healthcare**
    - Reassurances that our quality initiatives, staff and investment will never be less

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Greater Waterbury Health Network

Ensuring high quality healthcare into the future

- In late 2015, GWHN learned of CMS violations at Prospect's California hospitals. Board task force led further due diligence on quality assurance and performance improvement
- Rigorous process put in place to review Prospect's plan and processes for ensuring high quality healthcare

Greater Waterbury Health Network

QUALITY OF CARE: DUE DILIGENCE PROCESS

Susan Cordeau, BS, RN

Director, Performance Improvement

Waterbury Hospital

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Greater Waterbury Health Network

Close scrutiny of quality

- Task force of seven, representing medical staff, Board of Directors, nursing and quality/performance improvement
- Purpose:
  - review the IJ CMS survey violations of California-based hospitals,
  - review Prospect's actions
  - make a recommendation to the Board of Directors

Scope of review

- Requested all CMS deficiencies for all PMH hospitals for the last 3 years
- Areas of concern limited to California hospitals where there were several Immediate Jeopardy (IJ) findings
- Process included review of the IJ survey materials, follow-up questions and conference call with Prospect exec, on-site visits to CharterCare in Rhode Island and to Los Angeles County Hospital, Culver City

Initial concerns raised

- Will the quality of care of GWHN be maintained?
- Will there be adequate financial and human resources to ensure quality care into the future?
- How does Prospect handle significant challenges?

Specific issues identified in California hospitals

- Pattern of widespread ineffective sterilization processes
- Issues of temp and humidity control
- Leadership/governing body oversight
- Failure of hospital to follow through on its corrective action plans

Results

- Affected only three of the 14 Prospect hospitals; limited in scope
- Prospect approached the issue vigorously with both financial resources and experienced quality team
- Senior leader at Prospect extremely transparent and knowledgeable
- Provided detailed explanations and plans for changes

Results

- Discussed new corporate organizational structure
- Reiterated that quality needs to be controlled locally with corporate oversight and support
- Rhode Island experience very reassuring; adequate, timely resources consistently available

The changes that they were able to make in a short time reflect a commitment to quality and availability of deep financial resources.

Recommendation to move forward

- On Thursday, April 13, task force reported its process and findings to the Board of Directors
- Proposed the transaction with Prospect Medical Holdings move forward, with recommendations; approved unanimously by the Board of Directors

Recommendations

- Memorialized in Quality Assurance letter:
  - Maintain current quality programs
  - Continue in Joint Commission program
  - Maintain current reporting structure to local CEO and add corporate legal
  - Share evidence-based practices across system
  - Provide adequate financial resources for facility and staff

MEDICAL STAFF INVOLVEMENT

Carl Sherter, MD, Former Chief of Staff, Member of GWHN Board Transaction Committee

CONCLUDING REMARKS

GWHN and Prospect: Committed to Community

Mitchell Lew, MD, President, Prospect Medical Holdings
Von Crockett, Senior VP, Corporate Development, Prospect Medical Holdings
Jonathan Spees, Senior VP, Mergers & Acquisitions, Prospect Medical Holdings
Tom Reardon, President, Prospect Medical Holdings, East
Steve Aleman, CFO, Prospect Medical Holdings

01678

Greater Waterbury Health Network

PROSPECT MEDICAL
Quality Service ~ Quality Care

Who is Prospect?

We Operate Local Community Hospitals

- Local governance; local physician leadership
- Investment in hospitals and our communities
- Continued employment and creation of new jobs
- Expansion of programs/services to improve access and quality

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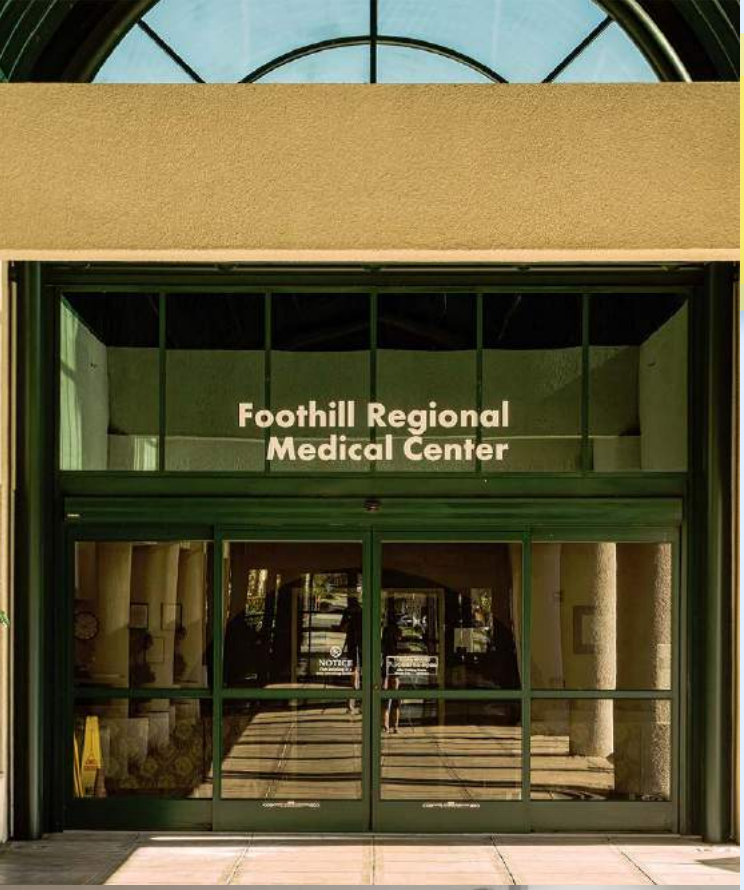

Our Hospitals

- 14 community hospitals in CA, TX, RI and NJ
- Serving many different communities
- Medical, surgical, tertiary/sub-specialty surgical, psychiatric and long-term care services
- Over 40 outpatient clinics and centers

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PROSPECT MEDICAL
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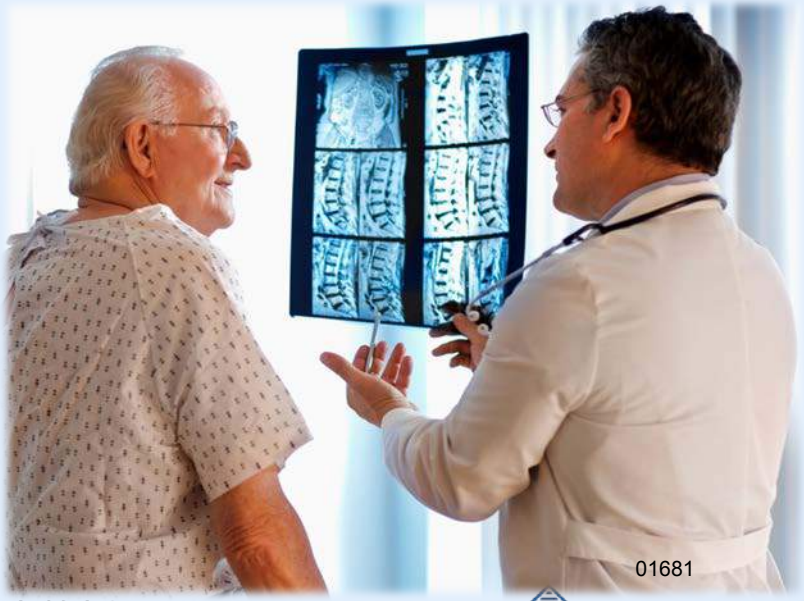
Our Medical Groups

Multi-Specialty Healthcare Provider Without Walls

- Independent Practice Association (IPA) physicians focused on delivering the best care
- Prominent Southern California medical groups
- Growing in TX, RI and NJ
- Contracted with all major health plans
- 8,900 primary care/specialist physicians
- 300,000-plus members
- Coordination of care across the entire continuum
- Goal is to achieve excellence in clinical outcomes and patient experience

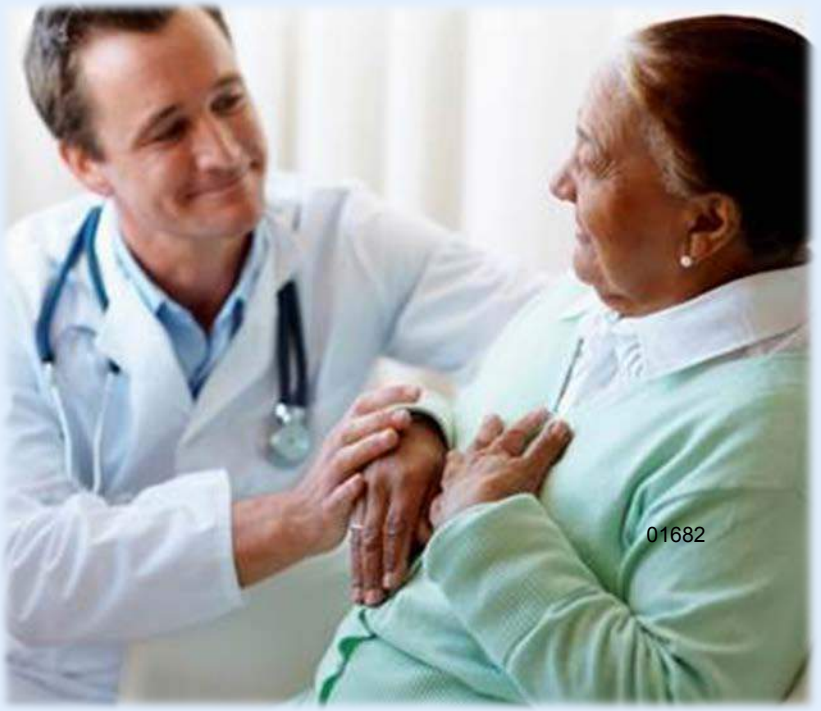


PROSPECT MEDICAL
Quality Service ~ Quality Care

Coordinated-Regional-Care

Prospect's Innovative Care Delivery Model

- Coordinated-Regional-Care (C-R-C) integrates hospitals, physicians and other medical and community providers, working closely with health plans and government payers to achieve improved patient care and satisfaction
  - Implemented in 7 regions in CA, TX and RI; in development in NJ, CT and PA
  - Population health management
  - Unique model of care provides higher value



Improved Care and Outcomes

Our Patient-Centered and Physician-Led Approach

- Multi-disciplinary care teams for high-risk patients (24/7)
- Patient and family engagement
- Homebound program
- Disease-specific care plans
- Integrated behavioral health
- Quality care coordinators (day-to-day outreach)
- Hospital/SNF/institutional case management
- Physician-led network

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Prospect's Financial Strength

Demonstrated History of Growth

Financial Performance

- Revenue compound annual growth rate (2011-15) 27.62%
- Adjusted EBITDA compound annual growth rate (2011-15) 25.57%

Acquisitions and Integration

- History of improved operational and financial performance with acquisitions
  - CharterCARE Health Partners
  - East Orange General Hospital
- Acquisitions accretive year one with improved performance

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Prospect's Financial Strength

Diversified Model = Strong, Predictable Free Cash Flow

- Medical Groups
  - Steady capitation payments and management fees
- Hospitals
  - Diversified payor mix
  - Multi-state platform
  - Predictable supplemental payments
- Ability to satisfy acquisition commitments without additional debt

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Prospect's Financial Strength

Access to Capital

- Conservative debt leverage ratio allows flexibility to raise additional capital

Industry Leverage Ratio Comparison	
Prospect	2.71X
HCA	3.7X
CHS	5.4X
Tenet	6.3X

- Access to capital markets (banks and bonds)
- Private equity group

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PROSPECT MEDICAL
Quality Service ~ Quality Care

Prospect's Commitment to Quality

Our Award-Winning Southern California Medical Groups

- California Association of Physician Groups (CAPG) Standards of Excellence Program – "Elite Status" (2012-2015)
- Integrated Healthcare Association (IHA) recognition of outstanding performance in "Meaningful Use of Health IT" and "Clinical Quality"
- Awards from the State of California Department of Managed Health Care (DMHC) for excellence in cardiovascular disease, cholesterol control and diabetes care
- 4 and 5 STAR – Medicare health plan quality and performance ratings

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Prospect's Commitment to Quality

Our Hospitals' Distinctions and Awards

- Blue Cross/Blue Shield (RI) Blue Distinction Center for Hip, Knee & Spine Surgery Programs, 2016 (Roger Williams Medical Center and Our Lady of Fatima Hospital, RI)
- American College of Surgeons-designated Academic Comprehensive Cancer Center, 2015 (Roger Williams Medical Center, RI)
- Joint Commission-certified for Advanced Primary Stroke Center, Diabetes Center and Joint Hip Replacement, 2015 (Our Lady Of Fatima Hospital, RI)
- Joint Commission Bariatric Center of Excellence (Nix Medical Center, TX)
- CareChex Awards – Top 10% nationwide – General Surgery (Nix Medical Center, TX); Vascular Surgery (Los Angeles Community Hospital, CA); Hip Fracture (Southern California Hospital at Culver City, CA)

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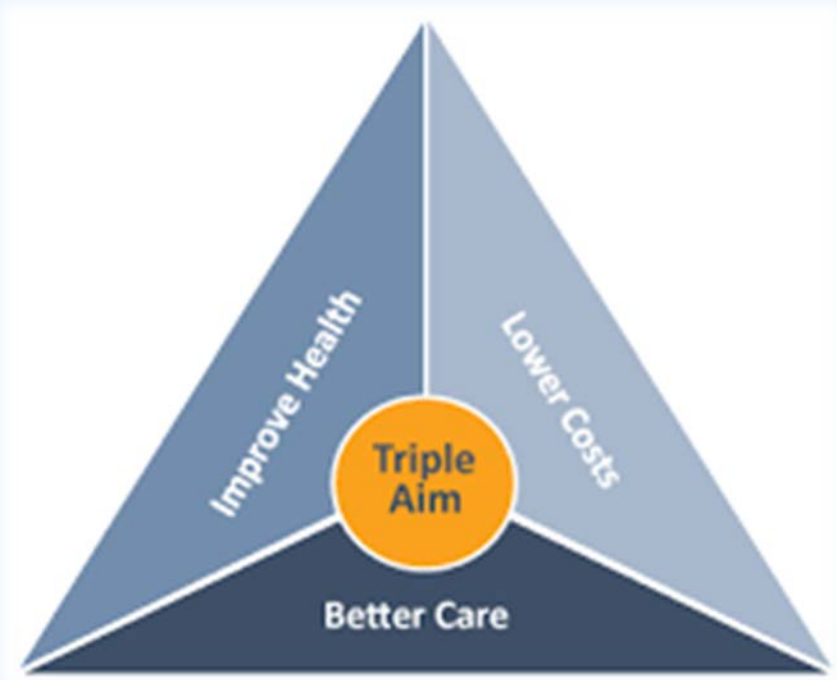
Prospect's Commitment to Quality

Quality Enhancements at California Hospitals

- Recent surveys at California hospitals
- Response to survey results
- Expectations for ongoing quality improvement



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Prospect's Commitment to Quality

Corporate Performance Improvement Program

- **Philosophy** – Right care/right time/right setting
- **Mission** – Outcomes, patient safety, integrity, communication and collaboration
- **Goal** – Become a high reliability organization promoting patient-focused, high-quality, safe, compassionate, efficient and effective care
- **Model** – Structure ➡ Process ➡ Outcomes
  - Donabedian quality of care framework

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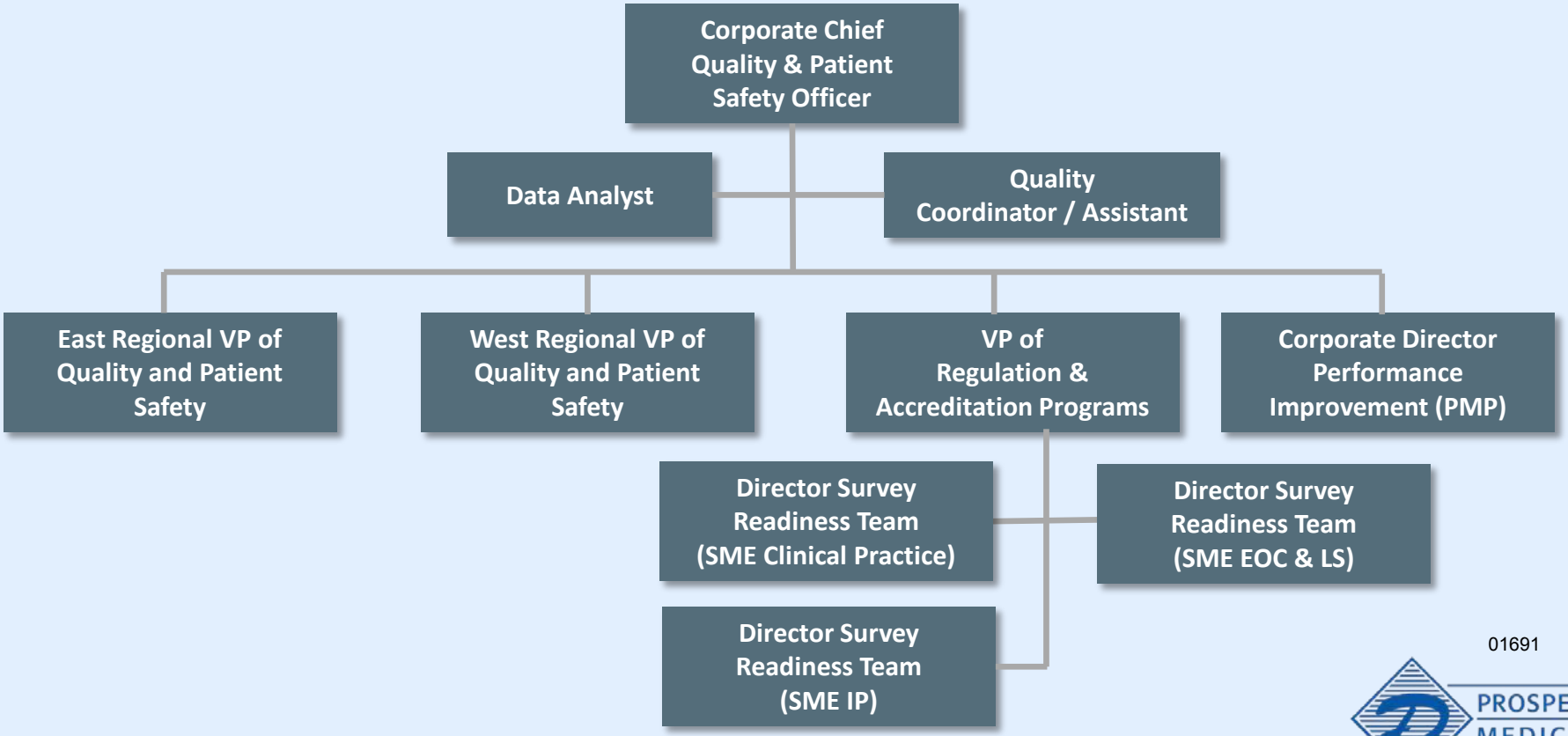
Prospect's Commitment to Quality

Corporate Quality Structure

Corporate and Regional Quality Department Structure



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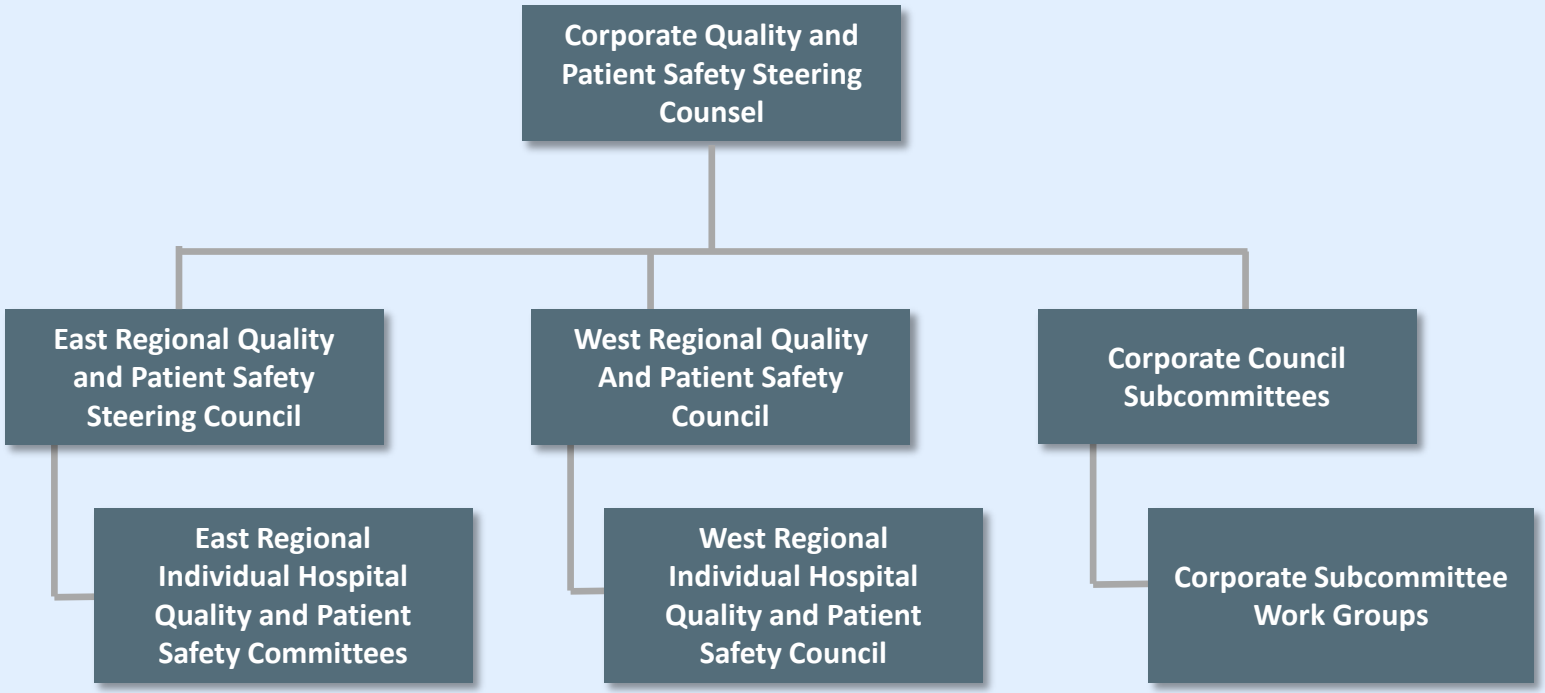
Prospect's Commitment to Quality

Quality/Patient Safety Reporting Structure

Quality and Patient Safety Communication and Reporting Structure



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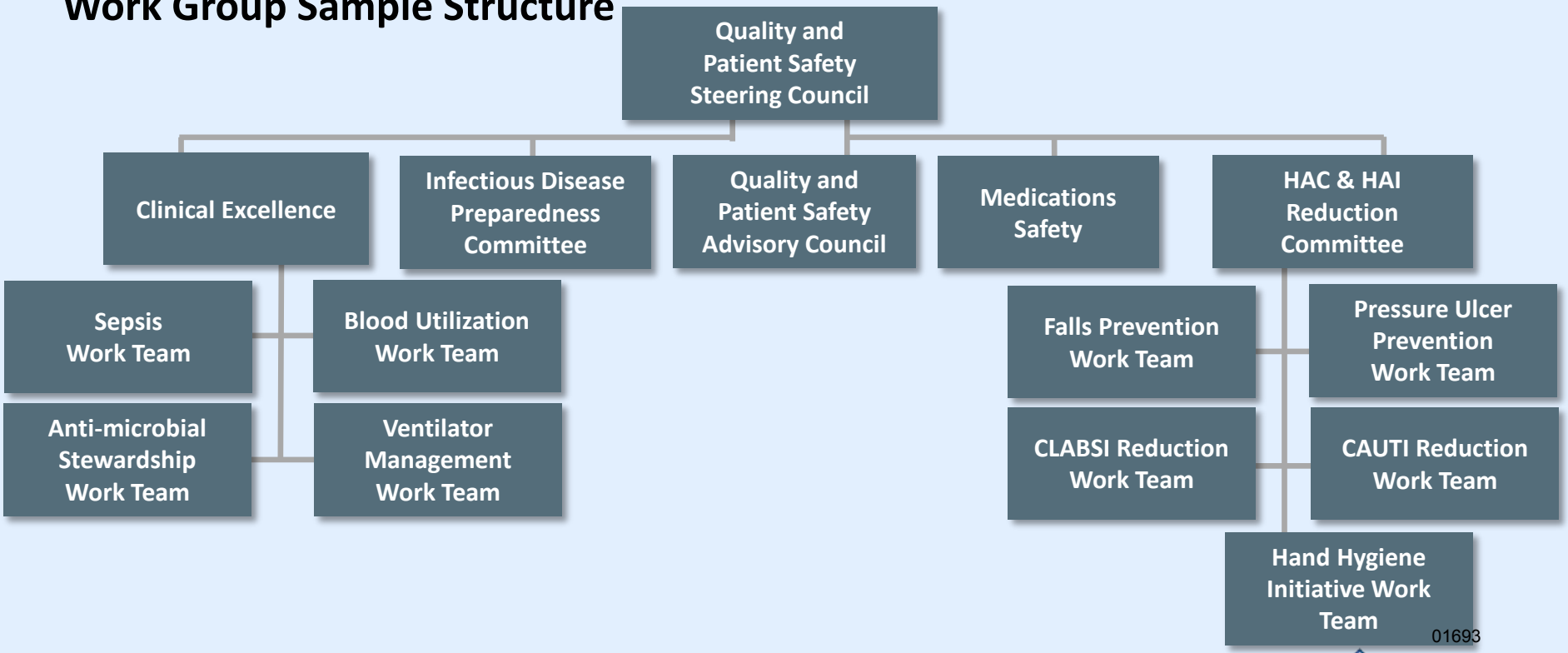
Prospect's Commitment to Quality

Quality/Patient Safety Steering Council Subcommittee

Corporate Quality and Patient Safety Steering Council Subcommittee/ Work Group Sample Structure



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Prospect's Commitment to Quality

Corporate Quality Improvement Process

- Adopting high reliability behaviors to ensure a reduction in overall medical errors
  - Leadership commitment
  - Just culture of safety
  - Widespread deployment of highly effective performance improvement tools

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Prospect's Commitment to Quality

Corporate Quality Improvement Strategies

- Support ongoing survey readiness
- Adopt patient experience, clinical excellence and high reliability best practices
- Create/adopt data dashboards and analysis tools
- Promote consistent risk identification and mitigation
- Optimize pay-for-performance and publicly reported outcomes
- Integrate technology

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Prospect's Commitment to Quality

Corporate Quality and Patient Safety Councils

- Analyze data and trends for performance improvement opportunities
- Assist with development of quality and patient safety agendas
- Provide organizational knowledge and systems thinking
- Motivate and strategize organizational change
- Ensure compliance with action items
- Provide oversight for chartered committees and work groups

01696

PROSPECT MEDICAL
Quality Service ~ Quality Care

Our Commitment to the Community

What Prospect Brings to GWHN

- Purchase price: $45 million
  - Subject to adjustments provided for in the Asset Purchase Agreement
- Capital expenditures: $55 million
  - Reduced for assumption of capital leases (up to a maximum of $3.5 million)
  - Reduced if assumed liabilities exceed the purchase price (up to a maximum of $5 million)
  - Reduced if post-closing claims due from GWHN to Prospect during the first three years after the closing are not paid (up to a maximum of $4.5 million)
  - Restructured (in consultation with the Local Board) if legal requirement that discriminates against for-profit hospitals materially affects Prospect

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Our Commitment to the Community

What Prospect Brings to GWHN

- Charity care – commitment to maintain current policies
- Management – commitment to local management
- Local advisory board – physicians and community leaders
- Medical staff – maintain and support
- Hospital services – maintain and grow
- Employees – hire all employees in good standing
- Quality – retain quality programs at Waterbury Hospital

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Quality Service ~ Quality Care

Role of GWHN's Local Advisory Board

Prospect's Commitment to Local Governance

- Consult with Prospect in developing post-closing strategic and capital plans, including modifications as appropriate to reflect changes in clinical practices, community need, reimbursement, etc.
- Responsible for medical staff credentialing
- Maintain and oversee the GWHN quality assurance program, including administration of the Quality Commitment Letter
- Oversee and manage accreditation

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GWHN Local Advisory Board Structure

Prospect's Commitment to Local Governance

- Initially 11 members
  - Five from current GWHN Board
  - Five physicians,
  - Hospital CEO
  - Will include Chief of Medical Staff and Senior Clinical Quality Executive
- Initial Local Board nominated by Governance Committee of the GWHN Board and approved by the GWHN Board, thereafter appointed by Prospect/GWHN management
- Staggered three-year terms

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PROSPECT MEDICAL
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GWHN Local Advisory Board Structure

Prospect's Commitment to Local Governance

- Board member selection criteria
  - Diversity in age, gender, race and town of residence with the goal of reflecting the communities served
  - Possess expertise and backgrounds that align with Local Board roles and responsibilities
  - Have demonstrated a commitment to GWHN's mission

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Prospect's Model in Practice

CharterCARE Health Partners Accomplishments

Prospect ...

- Formed a multi-specialty IPA with 100+ primary care providers
- Increased employed physicians by 50+
- Expanded outpatient clinics beyond service area
- Invested in outpatient oncology center
- Achieved academic certification of cancer center
- Provided significant strategic capital
- Is implementing Medicaid value-based pilot
- Works closely and efficiently with the Local Board

PROSPECT MEDICAL
Quality Service ~ Quality Care

Why Prospect?

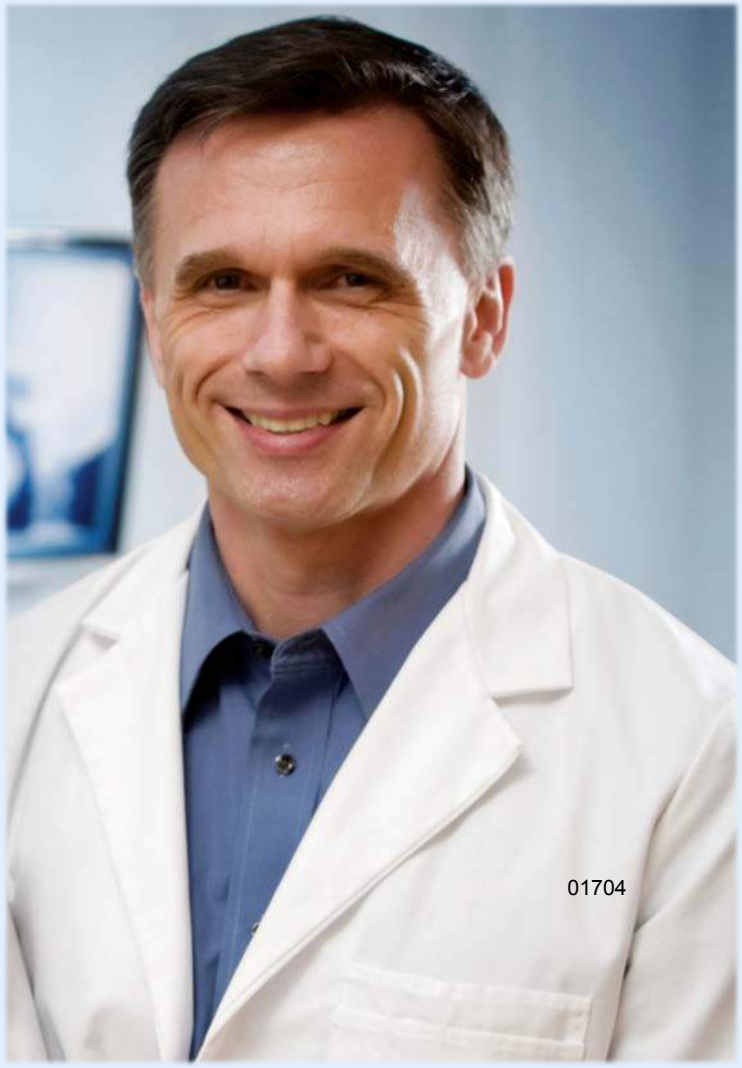
Prospect Offers a Unique Healthcare Delivery Model

- Promotes better community health
- Empowers local physicians
- Maintains/creates local jobs
- Provides extensive corporate resources/expertise to support local hospital operators
- Maintains local leadership with regional oversight
- Invests significant capital in facilities, service and technologies
- Preserves charity care policies

GWHN/Prospect Partnership Advantages

Quality + More Efficient Care = Better Value

- Integration of GWHN, physicians, community providers and health plans
- Better care and health of patients
- Higher patient satisfaction from personalized care
- Improved access to capital and financial strength
- Sustainable delivery model preserves Waterbury Hospital, physician practices and quality healthcare



Why Prospect?

GWHN and Prospect – Commitment to Community

- We are committed to Connecticut
- Our innovative delivery model will transform GWHN into a leader in Connecticut healthcare

Greater Waterbury Health Network

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Why Prospect?

Prospect and GWHN – Our Goals

HIGH Quality Care

HIGHER Patient Satisfaction

HIGHEST Value

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Greater Waterbury Health Network

PROSPECT MEDICAL
Quality Service ~ Quality Care

RONALD D'ANDREA, M.D.

April 15, 2016

Mr Gary Hawes, Esq

Assistant Attorney General

Office of the Attorney General

Dear Mr. Hawes,

As a member of the Waterbury Hospital medical staff for over 30 years, I would like to offer my support for the continued plans for a purchase transaction between Prospect Medical Holdings and Waterbury hospital.

Since joining the staff in 1979, I have been a practicing physician in the community delivering care to both children and adults. Being involved in many committees within the hospital has given me insight to both outpatient and inpatient challenges within the community and the hospitals. Increased demand by staffing and external challenges of decreasing reimbursements, an increasingly regulatory environment and an increasing patient demand have placed a remarkable strain on the hospitals in Connecticut and in particular Waterbury hospital and its resources.

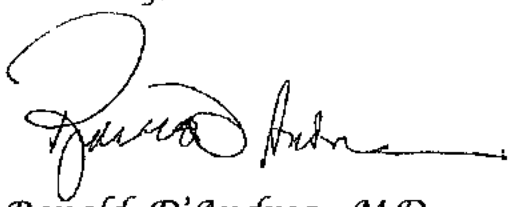
Other trends include specialty physicians opening satellite office in other communities not only to increase their patient base but also to allow their Waterbury patients access the other facilities outside the Waterbury area for their inpatient care. Failed mergers in the past and negative media coverage have encouraged patients to seek other

DEPOT SQUARE MALL 51 DEPOT STREET WATERTOWN, CONNECTICUT 06795
TELEPHONE (860) 274-5497

institutions outside of the Waterbury area for their outpatient care and, oftentimes, transferring to other physicians for the general care.

The transaction with Prospect Medical Holdings, in my opinion, will infuse not only capital but more of a sense of community and innovative technological advances which will increase both patient services and satisfaction. In addition, the economic health of both Waterbury Hospital and the city of Waterbury will be improved through an increase in revenue to promote more jobs and an increase in the tax base for the city of Waterbury.

Sincerely,



Ronald D'Andrea, M.D.

INTERAL MEDICINE, WATERTOWN

MEMBER, BOARD OF TRUSTEES, WATERTBURY HOSPITAL

DEPOT SQUARE MALL 51 DEPOT STREET WATERTOWN, CONNECTICUT 06795
TELEPHONE (860) 274-5497

April 15, 2016

Mr Steven Lazarus

Associate Health Care analyst

Office of Health Care Access

Dear Mr. Lazarus,

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Sincerely,

Ronald D'Andrea, M.D.

INTERAL MEDICINE, WATERTOWN

MEMBER, BOARD OF TRUSTEES, WATERTBURY HOSPITAL

Southbury Medical Associates, LLP
22 Old Waterbury Road Suite 201
Southbury, CT 06488
Telephone 203-264-6503
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Heather M. Nisbeth, M.D.
Jonathan Mosovich, M.D.
Elise M. Romanik, M.D.

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mister Hawes and Mister Lazarus,

I am a self-employed general internist in independent practice with Southbury Medical Associates in Southbury, and a member of the staff of Waterbury Hospital since 1997. Waterbury Hospital has been our primary hospital during that time. We have admitted the vast majority of our patients there over the years.

I am writing in support of the pending acquisition of Waterbury Hospital by Prospect Holdings. As a self employed physician, without financial connections to either Waterbury Hospital or Prospect Holdings, I think my opinion may be somewhat unique and of use to you in your deliberations.

Over the last decade or so, I have watched the facilities and the services at Waterbury Hospital suffer greatly from needless local competition. The only beneficiaries of this competition in Waterbury have been the health insurance companies who have driven reimbursement rates in Waterbury to very low levels. These savings have not been passed along to consumers, but only used to increase the insurers' corporate profits and their executives' salaries. Neither hospital in town has had sufficient capital to make improvements in their facilities, staff, and services and have lost significant numbers of physicians and patients to Danbury, New Haven and Hartford. Other cities of similar size, such as New Haven and Danbury, have been blessed with vigorous and well funded community hospitals which have provided world class services.

The two previous major attempts to rectify the situation in Waterbury both failed; first the merger with St. Mary's and then Waterbury's purchase by Tenet Corporation.

I have had the opportunity to visit the current perspective buyer, Prospect Holdings, in California, interview their staff and leadership and have worked on the new IPA with them. Prospect has extensive experience in managing and funding hospitals such as Waterbury throughout the country and has done a very good job recapitalizing declining

institutions, improving their competitive nature, and providing much better, higher quality services to their communities. Prospect has an enviable record nationwide in managing "value added care" and in creating risk based contracts with cost saving and improved coordination of care for patients.

I have also met with the doctors (both employees and independent) in Rhode Island who work at two Prospect acquired hospitals there. These physicians are very satisfied with the Prospect management and told me that Prospect rescued two failing institutions that are rapidly becoming viable and vigorous community resources.

Consequently, I can unequivocally support the proposed purchase of Waterbury Hospital by Prospect. I believe this is the best possible plan for the Waterbury community, current and future patients and the physicians.

I fear that this may be Waterbury Hospital's last chance. If this transaction is not completed, I wonder if the institution can remain viable. I urge you to decide in favor of the transaction.

Please contact me if you would like further information.

Fitzhugh C Pannill MD FACP
Southbury Medical Associates
22 Old Waterbury Road
Southbury CT 06488

THE HAROLD LEEVER
REGIONAL CANCER CENTER

A Partnership for Excellence
St. Mary's Hospital & Waterbury Hospital

Gary Hawes
Assistant Attorney General
Office of Attorney General

Steven Lazarus
Associate Health Care Analyst
Dept. of Public Health
Office of Health Care Access

Dear Sir,

I am writing in support of the proposed transaction between Waterbury Hospital/Greater Waterbury Health Network and Prospect Medical Holdings.
I am the Executive Director of The Harold Leever Regional Cancer Center which is an affiliate of the Waterbury Hospital/Greater Waterbury Health Network.

This is a high quality Health Network that is struggling to survive in the current health care environment due to declining reimbursement and increasing under insured population.
By joining a Health Care System like Prospect Medical Holdings Waterbury Hospital/Greater Waterbury Health Network will be able to continue to provide outstanding patient care while taking advantage of the efficiencies that a large health care system can provide, as well as provide for increased capital investment to meet the ever changing needs of the patient population.

We appreciate your consideration of this proposed transaction.

Sincerely,

Kevin Kniery
Excéutive Director
The Harold Leever Regional Cancer Center

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Sirs:

I am an employee of VNA Health at Home, Inc. and I am writing this letter in **support** of the Prospect Medical Holdings & Greater Waterbury Health Network Venture.

As an employee of VNA Health at Home, Inc., an affiliate company of the Greater Waterbury Health Network, I feel my role, serving patients in the community, will be enhanced by the partnership with Prospect Medical Holdings.

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I feel this venture will move, our network, in the direction to become a leader for advanced healthcare services in our state.

Sincerely Yours,

Stephanie Atwood

Title: Team Assistant
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Melissa Mason

Title: Team Coordinator
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Title: Intake Nurse
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Dara Rinaldi

Title: Staff Accountant
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Kathleen Cerchia
Scheduling Coordinator

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Michele M Gravel

Title: HR/Payroll & Benefits Coordinator
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Shelley Magel

Title: Billing Reimbursement Specialist
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Lauren Mayfield

Title: Data Management Assistant
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Jessie H Williams

Title: Mgr. Billing & Data Integrity
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Therese Cosgrove

Title: Medical Orders Records Assistant
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Title: Sr Billing Reimbursement Specialist
VNA Health at Home, Inc.

April 27, 2016

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Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Emily Swinnerton, RN

Title: RN. case manager
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Elizabeth Spagnuolo

Title: RN
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Loredana Grill

Title: LPN.
VNA Health at Home, Inc.

April 27, 2016

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Assistant Attorney General
Office of the Attorney General

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Associate Health Care Analyst
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Sincerely Yours,

Jennifer R Duffy LPN

Title: LPN
VNA Health at Home, Inc.

April 27, 2016

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Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Title: LPN
VNA Health at Home, Inc.

April 27, 2016

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Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,
Carla Lanucqre, RN

Title: RN Casemanager
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Tricia Rossi, LPN

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Pamela Belvedere RN
Utilization Management

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Title: Director / Clinical Operations
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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April 27, 2016

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Sincerely Yours,

Cheryl White RN
Title: RN
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Shelley Guevara RN

Title: Shelley Guevara RN
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

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Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Villanueva

Rebecca Villanueva
Title: BSN, RN - visiting nurse
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Janet Lena RN

Title: RN Case Manager
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
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Sincerely Yours,

Title: Clinical Manager
VNA Health at Home, Inc.

April 27, 2016

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Assistant Attorney General
Office of the Attorney General

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I feel this venture will move, our network, in the direction to become a leader for advanced healthcare services in our state.

Sincerely Yours,

Stacey Finne RN, BSN

Title: RN Case Manager
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Dawn Luddy RN

Title: RN Case Manager
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Angela Barbosa, MSRN
Clinical Liaison

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Megan Edson-Sawyer RN

Title: Megan Edson-Sawyer RN
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Pamela Antonio

Title: LPN
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Kim M Byron

Title: Registered Nurse
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Susan A Brown MSW

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Title: RN Director of Quality
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Judith A. Kondracki

Title: Director of Finance
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

President or Administrator

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Ellen L Allen

Title: Physical Therapist
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Elaine M Dabaei

Home Health Aide

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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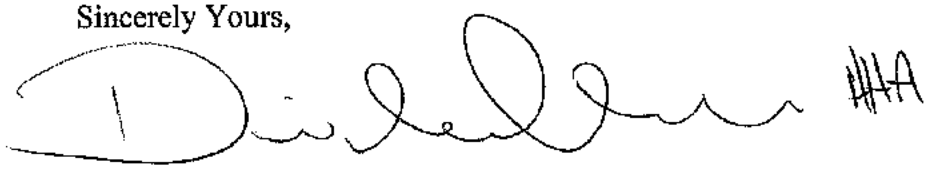

Title:
VNA Health at Home, Inc.

April 27, 2016

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Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Danielle Tranzese HHA

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Home Health Aide

Title:
VNA Health at Home, Inc.

April 27, 2016

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Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Jean Lombard-Knox CMHHA

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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Sincerely Yours,

Ushlle Gutowski

Title: HHA
VNA Health at Home, Inc.

April 27, 2016

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Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Patricia D. Paquette Cert. Home Hea Hh Aide

Title:
VNA Health at Home, Inc.

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely Yours,

Claudette Brice HHA

Title:
VNA Health at Home, Inc.

PETER C. GRECO, M.D.
NEUROLOGY AND ELECTROMYOGRAPHY
BOARD CERTIFIED

133 Scovill Street, Suite 214
Waterbury, CT 06706
Telephone (203) 753-6004
Facsimile (203) 755-3512

April 21, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes and Mr. Lazarus:

This letter is in regard to supporting the transaction between GWHN and Prospect Medical Holdings. My name is Dr. Peter Greco, Director of the Stroke Program at Waterbury Hospital. I have been an active Neurologist in the Waterbury area for greater than 35 years.

This partnership will benefit all the independent physicians and the patient's within the greater Waterbury region.

Sincerely,

Peter Greco, M.D.

WATERBURY HOSPITAL

April 28, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

I am an employee at Waterbury Hospital, working in both the emergency department and Information Systems. I have a first-hand understanding of the fiscal challenges facing our organization and the impact on both our patients and employees. Though we have taken numerous actions as a result—including cuts to employee wages and salaries— we cannot do it alone.

The transaction with Prospect Medical Holdings is essential to keep our hospital moving forward. This acquisition will enable our organization to not only survive but thrive well into the future. We all recognize that as healthcare changes, a strategic, capital partner is a must.

Waterbury Hospital is a special place that provides tremendous care, compassion, and service to our patients, their families, and our community. As the largest employer of the city and an organization that constantly strives for excellence, this organization is essential to the region.

For the welfare of our employees, patients, and community members that rely on Waterbury Hospital and the Greater Waterbury Health Network, your approval of this transaction is crucial.

Sincerely,

Peter T. Porrello

Peter T. Porrello

LIVE UNITED

United Way
United Way of Greater Waterbury

April 28, 2016

Mr. Gary Hawes
Assistant Attorney General
Office of the Attorney General

Mr. Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Sirs,

Waterbury Hospital/Greater Waterbury Health Network is a valued partner in United Way of Greater Waterbury's work in serving our community's most vulnerable. Waterbury Hospital's leadership and staff voluntarily serve on United Ways board, community impact committees and are critical to the success of our Annual Campaign, the dollars of which helped over 42,000 people in our service area last year. Waterbury Hospital also provides expertise to United Way on a regular basis in support of our work affecting the health of our community.

United Way of Greater Waterbury encourages and supports the current efforts that promise to provide a stable future for Waterbury Hospital/Greater Waterbury Health Network and that will allow the continuation of high quality, sustainable healthcare to our community.

Sincerely,

Kristen Jacoby

Kristen Jacoby, MPH
President/CPO

WATERBURY HOSPITAL

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

I am an employee at Waterbury Hospital, working in the Information Services Department. I have a first-hand understanding of the fiscal challenges facing our organization and the many actions—including layoffs, position cuts, cuts to employee wages and salaries—that have been taken to keep our hospital moving forward.

Waterbury Hospital is a special place that provides tremendous care, compassion, and service to our patients, their families, and our community. We rely on Waterbury Hospital for healthcare as well as for employment. This hospital is an essential organization to the life and well-being of our community.

The transaction with Prospect Medical Holdings is essential. Healthcare is changing and a strategic, capital partner is a must. This acquisition will enable our organization to not only survive but thrive well into the future. On behalf of our employees, patients, and community members that rely on Waterbury Hospital and the Greater Waterbury Health Network, I urge you to approve this transaction.

Thank you!

Sincerely,

Karen Skiba RN, BS
Senior Clinical Informatics Analyst
Waterbury Hospital
203-573-7349

WATERBURY HOSPITAL

April 26, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes and Mr. Lazarus:

I am an employee at Waterbury Hospital, working in the Information Systems Department. I have a first-hand understanding of the fiscal challenges facing our organization and the many actions—including cuts to employee wages and salaries—that have been taken to keep our hospital moving forward.

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I believe that the transaction with Prospect Medical Holdings is essential. This acquisition will enable our organization to not only survive but thrive well into the future. We all recognize that as healthcare changes, a strategic, capital partner is a must. On behalf of our employees, patients, and community members that rely on Waterbury Hospital and the Greater Waterbury Health Network, I urge you to approve this transaction.

Thank you!

Sincerely,

Jan Balzarini

Jan Balzarini

WATERBURY HOSPITAL

April 26, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

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Thank you!

Sincerely,

Suzanne M. LeMoine

Suzanne M. LeMoine
Manager of Decision Support

WATERBURY HOSPITAL

April 26, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
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I believe that the transaction with Prospect Medical Holdings is essential. This acquisition will enable our organization to not only survive but thrive well into the future. We all recognize that as healthcare changes, a strategic, capital partner is a must. On behalf of our employees, patients, and community members that rely on Waterbury Hospital and the Greater Waterbury Health Network, I urge you to approve this transaction.

Thank you!

Sincerely,

WATERBURY HOSPITAL

April 27, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

I am an employee at Waterbury Hospital, working in the Information Systems Department. I have a first-hand understanding of the fiscal challenges facing our organization and the many actions—including cuts to employee wages and salaries—that have been taken to keep our hospital moving forward.

Waterbury Hospital is a special place that provides tremendous care, compassion, and service to our patients, their families, and our community. We all rely on Waterbury Hospital—whether for care, employment, or simply the reassurance of having a facility close by to help keep us healthy or help us deal with life's emergencies. This is definitely an organization that is essential to the life of our community.

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Thank you!

Sincerely,

Jean Gagnon

P.O. Box 12

Winchester Center, CT

Steven Lazarus

Associate Health Care Analyst

Department of Public Health

Office of Health Care Access

Dear Mr. Lazarus,

I am writing to add my name to the list of supporters for the proposed acquisition of Waterbury Hospital et al. by Prospect Medical Holdings.

I have been traveling down Route 8 from the Winsted area for 15 years to work in the cardiology department at Waterbury Hospital. Despite all of the challenges and changes in the medical field and economic hardships during that time, I have been proud of the care and respect that we show our patients.

I have no doubt whatsoever that this transaction with Prospect reflects the changing times that we live in. Change may be scary and uncomfortable but in the long run, Prospect can give us the resources to target the needs of our community for the long haul.

I ask that you support this transaction.

Sincerely,

Joy Hale, BA, RDCS

P.O. Box 12

Winchester Center, CT

Gary Hawes

Assistant Attorney General

Office of the Attorney General

Dear Attorney Hawes,

I am writing to add my name to the list of supporters for the proposed acquisition of Waterbury Hospital et al. by Prospect Medical Holdings.

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I ask that you support this transaction.

Sincerely, Joy E Hale RDCS

Joy Hale, BA, RDCS

WATERBURY HOSPITAL

April 26, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

I am an employee at Waterbury Hospital, working in the Finance Department. I have seen first-hand the fiscal challenges facing our organization and the many actions—including cuts to employee wages and salaries—that have been taken to keep our hospital moving forward. Regardless of these challenges, I arrive to work each day and am amazed by the positive atmosphere and the dedicated employees that drive this organization.

Waterbury Hospital is a special place that provides tremendous care, compassion, and service to our patients, their families, and our community. We all rely on Waterbury Hospital—whether for care, employment, or simply the reassurance of having a facility close by to help keep us healthy or help us deal with life's emergencies. This is definitely an organization that is essential to the life of our community.

I believe that the transaction with Prospect Medical Holdings is essential. This acquisition will enable our organization to not only survive but thrive well into the future. We all recognize that as healthcare changes, a strategic, capital partner is a must. On behalf of our employees, patients, and community members that rely on Waterbury Hospital and the Greater Waterbury Health Network, I urge you to approve this transaction.

Thank you!

Sincerely,
Brooke Trillo
Budget Manager

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steve Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

May 11, 2016

Dear Attorney Gary Hawes and Associate Health Care Analyst Steven Lazarus:

I write this letter in support of the proposed transaction between GWHN and Prospect Medical Holdings.

For background purposes, I have lived in the city of Waterbury for over 50 years. I currently serve as the Director of the University of Connecticut Waterbury campus. Additionally, I serve as a Waterbury Police Commissioner, serve as First Vice Chairman of the Chamber of Commerce, and serve as a Director on the Board of the Northwest Regional Workforce Investment Board in Waterbury as well. I had the honor of being chosen mayor for the day, a few years ago in the city. Most significantly, I have the distinct honor and privilege of serving on the Waterbury Hospital Board of Directors and have done so for the past nine years.

With respect to Waterbury Hospital, its mission of providing sustainable, high quality, accessible healthcare for the region is truly one of the city's greatest assets. The proposed transaction between GWHN and Prospect Medical Holdings would enhance the hospital's mission and its ability to serve the thousands of patients throughout the region who rely on Waterbury Hospital, its highly skilled physicians and its commitment to maintaining charity care.

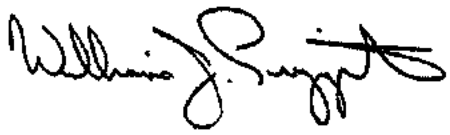
The transaction would provide the necessary resources to enhance the hospitals services to patients by renovating outdated facilities and providing state of the art equipment to deliver the latest services and procedures to patients;

From a fiscal perspective, the transaction would create a taxable, for-profit health care system that would provide substantial tax revenue to both the City of Waterbury and the State of Connecticut;

Lastly, the transaction would preserve and enhance Waterbury Hospital's role as a leading provider of high quality health care service so desperately needed in the urban areas of our state. With a catchment area of hundreds of thousands of people in the greater Waterbury region, the need for skilled physicians to service a growing elderly population and the lack of resources for state of the art equipment, point, in part, to the critical need for this proposed transaction to occur.

Please accept this letter of support for the proposed transaction between GWHN and Prospect Medical Holdings. I thank you for your time and consideration.

Respectfully Yours,



William J. Pizzuto, Ph.D.
University of Connecticut

Director, Waterbury Campus
99 East Main Street
Waterbury, CT 06702
Tel. 203-236-9818
Fax 203-236-9820
Email: William.Pizzuto@uconn.edu

WATERBURY HOSPITAL

April 26, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

I have been an employee of Waterbury Hospital since 1985. I've worked in many different areas of the hospital and have had the pleasure of working with a variety of people. In fact, I view Waterbury Hospital as my home away from home. The relationships I have mad with people will last throughout my lifetime. The people at Waterbury Hospital are remarkable, compassionate and talented caregivers. I am constantly amazed at the levels that people will go to make sure we always deliver excellent, patient-centered care, making sure we always put out patients and families first.

Continuing our legacy of excellence requires that we have a partner who can help us navigate the changing healthcare system. I have been impressed with Prospect and their hands on approach to helping us meet our goals and I look forward to working with them in the future. I urge you to approve this transaction as quickly as possible—it's important for our patients, community, and our future.

Thank you!

Sincerely,

Beth Grant

Beth Grant

WATERBURY HOSPITAL

April 26, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

This letter is in support of the purchase of the Greater Waterbury Health Network by Prospect Medical Holdings.

As the Medical Director of the Emergency Department at Waterbury Hospital, I am intimately involved in the management of a key part of the region's safety net. Our Emergency Department treats over 50,000 people each year, many of which are the most vulnerable members of our community. To do this, we must continue to provide dedicated personnel and have the best equipment and supplies available.

Prospect Medical Holdings has committed to invest in our hospital's infrastructure to enable us to improve existing services and to continue to provide high level care to the community 24/7. This type of investment is critical for both the hospital and the community. As a crucial part of the region's safety net, Waterbury Hospital's ED provides state-of-the-art trauma, cardiac, and neurologic care for anyone who requires either emergent or urgent care. To maintain and grow these types of services requires the ability to attract high quality staff and support them with investment in key areas of healthcare infrastructure.

The purchase by Prospect will also provide needed stability that will encourage the development of new and approaches to the delivery of healthcare. These innovations will enable us to be successful in navigating the changing healthcare environment while continuing our commitment to delivering the highest quality of care to the Waterbury community.

Thank you for your consideration.

Sincerely,

David Goldwag, MD

Connecticut Community Foundation
Timeless Impact

April 22, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes and Mr. Lazarus:

I am writing you in support of the proposed transaction between the Greater Waterbury Health Network (GWHN) and Prospect Medical Holdings. I serve as a member of GWHN and in my capacity at the Connecticut Community Foundation, I have been actively engaged in supporting a community-wide health improvement effort, coordinated by the Waterbury Health Department, in partnership with several other key organizations including Waterbury Hospital. Through the past four years of working with this partnership, I have been impressed by the caliber of professionals at GWHN and their deep commitment to this community.

Having personally witnessed the important role that Waterbury Hospital plays in improving health outcomes for local residents and mobilizing parents to take charge of their families' well-being, I am convinced that Waterbury Hospital is an institution that is fundamentally important to the Greater Waterbury community. I believe that the proposed transaction is our best hope for ensuring that Waterbury Hospital not only survives, but thrives in fulfilling its mission.

As you well know, the hospital has emerged from being extremely vulnerable and is on a path toward a sustainable future. I've looked into the practices of Prospect Medical Holdings and believe that their operating model will further advance quality, decrease costs and heighten patient care. They are well-regarded for sound business practices and are a good fit with the excellent team of administrators who are guiding Waterbury Hospital toward its future. With ongoing guidance from community members who will serve on their advisory board and foundation board, I believe community health needs will continue to be addressed and improved.

It's time for this transaction to be approved and allow our community's hospital and its leadership to turn important attention to toward fulfilling its mission. They've done their due diligence and have forged a positive alliance with an innovative company that will make a world of difference in Waterbury.

I urge you to do what you can to move this acquisition of GWHN by Prospect Medical Holdings forward. It is the right company and it's the right time for Waterbury Hospital to move ahead.

Sincerely,

Paula Van Ness
President & Chief Executive Officer

43 Field Street | Waterbury, CT 06702 | 203.753.1315 | www.conncf.org

Mark H. Holtz, MS, FACHE
656 Championship Drive
Oxford, CT 06748

April, 26, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes, and Mr. Lazarus,

I am the current Senior Vice president and Chief Operating Officer of the Greater Waterbury health Network. I joined the organization in March of 2015. I am very much in support of the acquisition of the Greater Waterbury Health Network by Prospect Medical Holdings for several reasons.

I have been in the profession of healthcare administration for over 37 years in a variety of hospital organizations, including private, not for profit, academic, for profit, and independent community hospitals. I have seen the evolution of healthcare delivery from many vantage points. I strongly believe that the Community Care model that Prospect Medical Holdings will bring to the state of Connecticut, and the city and surrounding community of the city of Waterbury is the future of healthcare delivery for our nation. Focus on keeping patients healthy and caring for them in the appropriate way, in the appropriate setting in a timely basis is the only way to stem the unsustainable rise in healthcare costs and maintain the quality of care we have been accustomed to. With this model of care and investment in the facilities and services of Waterbury Hospital this transaction will preserve an invaluable resource for our community. As a resident of Oxford, Waterbury is not only my place of employment, but it is my hospital. The place my family and I will come to in times of medical need. Please approve this transaction. This community needs it to happen for the present and for our future.

Thank you for your consideration.

Sincerely,

Mark Holtz, MS, FACHE
Senior Vice President and Chief Operating Officer
Greater Waterbury Health Network

Mr. Gary Hawes
Assistant Attorney General
Office of the Attorney General

Dear Mr.Hawes

I am writing you in reference to the proposed transaction between GWHN and Prospect Medical Holdings. I am a pharmacist who has worked at Waterbury Hospital for the past 10 years and in that time,I have seen some turbulent times here at Waterbury Hospital with many changes in the financial position of the healthcare climate. Through all of these difficult times the hospital has persevered and I believe, has built an amazing health system with many fine qualities and some of the best staff I've ever worked with.

I believe the transaction between us and Prospect Medical with give us the ability to prepare ourselves for the future of healthcare in our region. Prospect's investment in our future will allow us to make renovations, purchase much needed updated equipment and will help us to build a strong hospital which will serve our community for many years to come. In a very uncertain healthcare environment, the influx of capital and support that Prospect will afford our hospital is a needed boost to keep us a strong provider of care to the greater Waterbury area and its surroundings.

I give this proposed transaction my strongest support.

Thank you,

Sean J.Johnston, Rph

Frank A. Sherer, Jr.
63 Judson Ave
Woodbury, CT 06798

April 24, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

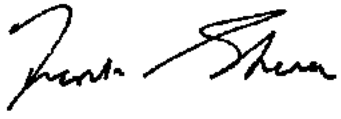
Dear Mr. Hawes and Mr. Lazarus,

This letter is written in support of the proposed transaction between Waterbury Hospital and Prospect Medical Holdings. I am a resident in Woodbury CT, and have lived in the greater Waterbury area served by Waterbury Hospital for almost 40 years. The hospital has been an important part of my life, handling broken bones and other emergencies for my five children, and in fact being the place where four of them were born.

I am also a member of the Board of Directors of Waterbury Hospital, and have been active in the community for many years, including serving as a member of the Board of Directors and Senior Vice President and General Counsel of Timex Group, based in Middlebury CT, and serving on the Board of Directors of the United Way of Greater Waterbury, as well as several Woodbury governmental boards.

The transaction should be approved for many reasons. New medical technologies require large capital investments, which the hospital will have difficulty funding on its own. Governmental support to hospitals is being reduced, making it even more difficult for them to meet their commitments to serve all segments of our community, including the most disadvantaged. Approval of the transaction with Prospect will allow Waterbury Hospital to meet these challenges, and continue to provide the full range of services necessary to meet all of our community's healthcare needs.

Sincerely yours.



Frank A. Sherer, Jr.
63 Judson Ave
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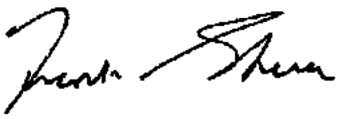

Frank A. Sherer, Jr.
63 Judson Ave
Woodbury, CT 06798

April 24, 2016

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Office of the Attorney General

Steven Lazarus
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Department of Public Health
Office of Health Care Access

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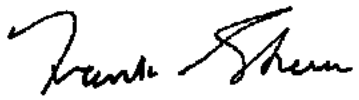

DIAGNOSTIC RADIOLOGY ASSOCIATES
Trusted Care Since 1974

Women's Imaging Center

Kenneth Allen, M.D. | John DeLeon, M.D. | Justin Champagne, PA-C
Duncan Belcher, M.D. | Eric Hyson, M.D. | Daniel DeJesus, PA-C
Stewart Berliner, M.D. | Andrew Lawson, M.D. | Ross Utter, PA-C
Anthony Carter, M.D. | Marco Verga, M.D.

20 April 2016

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106

Dear Sir:

I have practiced Diagnostic Radiology at Waterbury Hospital for the past 31 years during which time the health care needs of the poor have increased and reimbursements have declined to the point that they are inadequate. In order to continue its mission of providing the best health care to the people of Waterbury, the hospital needs to have a strong financial partner. That is why I fully support the proposed transaction between the Greater Waterbury Health Network and Prospect Medical Holdings.

Sincerely,

A Carter MD

Anthony R Carter, MD
Diagnostic Radiology Associates, LLC
134 Grandview Ave., Suite 101
Waterbury, CT 06708

Anthony J Cusano, MD
Connecticut Kidney and Hypertension Specialists
140 Grandview Ave
Waterbury, CT 06708

April 15, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Dear Mr. Hawes,

I am writing this letter regarding the purchase of Waterbury Hospital Health Center by Prospect Medical Holdings. I have been a voluntary attending physician in Waterbury at both hospitals for 27 years. I have also trained, worked or attended at 9 other hospitals around the country over my career in medicine. I have been an executive in several managed care organizations, as well as on the Board of Aetna Health Care.

Prospect Medical Holdings brings sophisticated management expertise, financial resources, and a commitment to value based healthcare that will enhance the healthcare infrastructure of Waterbury in particular and Connecticut in general. They provide an opportunity to improve access, quality and innovation in the healthcare system of our state.

Please look at the entire system, and especially the individuals who invest their hard earned money into their own health care financing when evaluating this transaction. If you do, you will see that this purchase should be approved.

Sincerely,

Anthony J Cusano, MD

Anthony J Cusano MD

Assistant Clinical Professor, Yale University School of Medicine
Assistant Professor, Quinnipiac University Frank H. Netter, M.D. School of Medicine

Anthony J Cusano, MD
Connecticut Kidney and Hypertension Specialists
140 Grandview Ave
Waterbury, CT 06708

April 15, 2016

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

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Sincerely,

Anthony J Cusano, MD

Anthony J Cusano MD

Assistant Clinical Professor, Yale University School of Medicine
Assistant Professor, Quinnipiac University Frank H. Netter, M.D. School of Medicine

4-22-16

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Sirs:

My name is Michael Myers. I am the Radiology Manager at Waterbury Hospital. I would like to express to you how I feel about the upcoming acquisition of Waterbury Hospital by Prospect Medical Holdings. I was hired in February and as you know the transaction was far from complete at that time. Knowing this I still decided to commit myself to the organization and come to work for them. I was willing to take the educated risk in the hopes that this project would have a positive outcome. I came from a hospital in Maine that had recently been acquired by a neighboring hospital. I felt the personal and vocational pain of the adjustment. I have faith in the Prospect deal for the following primary reasons.

- For-Profit businesses are geared for success. They are in the business of identifying opportunities and using them to advance their cause. In cases like Waterbury's, Prospect sees an opportunity and has the vision and skills to make Waterbury work for the community. Both Waterbury Hospital and Prospect Medical have a clear plan based on a proven history and both parties have the combined expertise to implement it.
- Waterbury Hospital will benefit not only from the innovative management expertise that Prospect offers, but will also benefit greatly from the financial resources that will be made available. It's not just the infusion of capital, it's the management of the capital that makes the difference. The people at Waterbury know what they need. Prospect agrees and can make it happen.
- In the end the people most affected are the patients. A fiscally healthy and well managed hospital is the only kind of healthcare facility that can help its community.

I thank you so much for reading my letter and allowing my input. The people at Waterbury Hospital are truly extraordinary and are ideally poised to provide world class healthcare to our community with the advent of this remarkable partnership.

Regards,
Michael Myers, CNMT, NCT, RT(R), (N)
Radiology Manager
Waterbury Hospital
Waterbury, CT

Mr. Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Lazarus

I am writing you in reference to the proposed transaction between GWHN and Prospect Medical Holdings. I am a pharmacist who has worked at Waterbury Hospital for the past 10 years and in that time, I have seen some turbulent times here at Waterbury Hospital with many changes in the financial position of the healthcare climate. Through all of these difficult times the hospital has persevered and I believe, has built an amazing health system with many fine qualities and some of the best staff I've ever worked with.

I believe the transaction between us and Prospect Medical with give us the ability to prepare ourselves for the future of healthcare in our region. Prospect's investment in our future will allow us to make renovations, purchase much needed updated equipment and will help us to build a strong hospital which will serve our community for many years to come. In a very uncertain healthcare environment, the influx of capital and support that Prospect will afford our hospital is a needed boost to keep us a strong provider of care to the greater Waterbury area and its surroundings.

I give this proposed transaction my strongest support.

Thank you,

Sean J.Johnston, Rph

GERALD R. BERG, MD

4/22/14

To:
Steven Lavigueur Associate Health Care Analyst
Dept of Public Health
OHCA

Dear Mr Lavigueur

my name is Gerald R. Berg MD. I practiced Diagnostic Radiology at Waterbury Hospital from 1974 – 2013. As the Chairman of the Department I was acutely aware of the difficulties in keeping up the department to State of the art standards in the area of equipment, staffing etc. Since Waterbury is a relatively poor community at risk in Medicare and Medicaid for much of its reimbursement and has a high percentage of severe asthmatics.

The proposed transaction between GWHH and Prospect will greatly strengthen our hospitals ability to serve our community. I am retired but continue to support Waterbury and St Mary's Hospitals.

Please support the merger of Prospect + GWHH /Gerald R Berg MD

To:

GERALD R. BERG, MD

4/22/16

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Dear Mr. Hawes,

My Name is Dr. Gerald Berg, I practiced Radiology of Waterbury for 1974 – 2013. As the Chairman of the Department of Radiology I was acutely aware of the difficulties of keeping the Dept. up to date with new equipment, staffing etc. Since Waterbury is a relatively poor community, we relied on Medicaid + Medicare for a large proportion of fees and were always underfunded.

The proposed transaction between CHHN + Prospect Medical Holding will greatly strengthen our hospitals ability to serve our community.

I remain committed to the success of my hospital. Hope I can retired and teaching at Yale + Better Best, Gerald R. Berg, MD

BIZZOZERO
51 CURTIS FARM ROAD
MIDDLEBURY, CONNECTICUT
06762

April 22, 2016

Mr. Gary Hawes
Assistant Attorney General
Office of the Attorney General

Dear Mr. Hawes,

I want to offer my support and positive vote in favor of the merger between The Waterbury Health Network of Waterbury Connecticut and Prospect Holdings of California. Such a combination would go a long way in strengthening our community hospital commitment to the Greater Waterbury Area and continue our commitment of superior Health Care to our community. As you are aware, most community Hospitals need capital partners if they are to survive in the current environment. Prospect's commitment to Patient Service is a model that is similar to ours and makes this combination a natural one to pursue.

I know you have concerns about for Profit entities getting involved in Health Care in Connecticut. We share those concerns, but feel that Prospect Holdings has much the same culture and ethic about Health Delivery that we have. We have gotten to know them quit well and feel comfortable about going forward with this relationship.

I was born and raised in the Waterbury and have been a physician here for over forty years. I am actively involved in helping to lead Waterbury Hospital into our next phase of caring for our community.

Please look favorably on this merger. Our community needs this for their future as well.

Sincerely,

O Joseph Bizzozero Jr. MD FACP FCCP
Director of Quality
Alliance Medical Group
Waterbury, Connecticut

BIZZOZERO
51 CURTIS FARM ROAD
MIDDLEBURY, CONNECTICUT
06762

April 22, 2016

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Associate Health care Analyst
Department of Public Health
Office of Health care Access

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Sincerely,

O Joseph Bizzozero Jr. MD FACP FCCP
Director of Quality
Alliance Medical Group
Waterbury, Connecticut

WATERBURY HOSPITAL

April 21, 2016

Gary Hawes

Assistant Attorney General

Office of the Attorney General

Steven Lazarus

Associate Health Care Analyst

Department of Public Health

Office of Health Care Access

Dear Assistant Attorney General Hawes and Mr. Lazarus:

I am an Infectious Disease specialist who has been practicing medicine in the Greater Waterbury community for 19 years. I originally came to Waterbury in 1988 as a medical student in order to do third year clerkships at St. Mary's Hospital. In 1991, I was accepted into the Yale-Primary Care (YPC) Residency Program. At that time, the YPC Program was based out of both Waterbury Hospital and St. Mary's Hospital. I had the good fortune of working with amazing clinician educators at both sites, including Dr. George Thornton who was instrumental in my decision to pursue sub-specialty training in the field of Infectious Disease. After my sub-specialty training at Yale-New Haven Hospital, I returned to Waterbury in 1997 to join the Infectious Disease Section and medical staff of Waterbury Hospital. My wife Leigh (who has worked at St. Mary's Hospital for over 30 years) and I lived in Waterbury briefly before moving to Naugatuck where we currently own a home, and all three of our children were schooled in Waterbury at St. Mary's School and Sacred Heart High School.

Over the past 19 years, as a proud employee of Waterbury Hospital/Alliance Medical Group, I have provided high-quality inpatient and outpatient Infectious Disease care to the greater Waterbury community; developed and maintained a premier clinic for people living with HIV/AIDS; and served as core faculty for the on-site residency training program. Throughout my career, I have witnessed dramatic changes in healthcare, but the current transformation is truly unique. Each year, novel diagnostics and therapeutics are introduced, allowing physicians from all disciplines to improve the quality and duration of life for their patients. While these

advances have changed the face of medicine, simultaneous cutbacks in reimbursement from state and federal governments as well as commercial insurers have hindered our ability to keep pace. At Waterbury Hospital, we are facing unprecedented financial challenges and acknowledge that our future is dependent on having a strong strategic and capital partner.

I strongly support the proposed transaction between GWHN and Prospect Medical Holdings. I believe that it will allow us to strengthen our ability to provide the Waterbury community with access to the high-quality, state-of-the-art healthcare services they deserve. I encourage you to approve this transaction.

Sincerely yours,

Steven I. Aronin, MD, FACP, FIDSA
Chief, Section of Infectious Disease
Hospital Epidemiologist
Waterbury Hospital
Medical Director
Waterbury Hospital Infectious Disease and Travel Clinic
Program Director
Ryan White Part C-EIS Grant
Scientific Director
Yale-Waterbury Hospital Internal Medicine Residency Program
President
Connecticut Infectious Disease Society
Associate Clinical Professor of Medicine
Yale University School of Medicine

The Rev. Robert and Mrs. Nancy Rhodes

64 SUNRISE ROAD
WOLCOTT, CONNECTICUT 06716-2642

April 18, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

We are writing to express our support for the proposed transaction between GWHN and Prospect Medical Holdings.

As supporters, volunteers and patients we are aware of the changes in the medical climate of today and the need for changes in the way things have been done.

We both look forward to the future of GWHN and Prospect Medical holdings.

Robert E Rhodes Jr.

the Rev. Robert E. Rhodes, Jr.
Retired United Methodist Minister

Nancy W. Rhodes

Nancy Warner Rhodes
President Waterbury Hospital Auxiliary

Easter Seals
Greater Waterbury, Central, and Northwest Connecticut
22 Tompkins Street, Waterbury, CT 06708
Phone: 203-754-5141 Fax: 203-757-1198
www.easterseals.com/waterburyct

April 18, 2016

Attorney Gary Hawes
Assistant Attorney General
Office of the Attorney General

Mr. Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus,

Please accept this letter which confirms my full support of the proposed transaction between the Greater Waterbury Health Network and Prospect Medical Holdings. Currently I am the President of Easter Seals of Greater Waterbury, a non-profit disability organization serving greater Waterbury and Central Connecticut. Easter Seals is a partner with Waterbury Hospital in the ownership of Access Rehabilitation Centers which operates multiple clinics offering Physical and Occupational Therapy throughout the area. I have been an active member of the Waterbury healthcare and business community for the past 11 years.

As a community Waterbury will benefit from the expertise in population health management that Prospect brings to our region. That, along with capital investments in infrastructure and technology and commitment to quality care and improving healthcare outcomes make this company the best partner for our community hospital. Prospect has demonstrated that it is willing to hire all current employees and assume collective bargaining agreements. In the Waterbury Hospital employee community, staff is overwhelmingly eager for this transaction to take place. I urge you to approve this application which will benefit those of us who live, work and seek care in this community.

Sincerely,

Loraine C. Shea,
President, Easter Seals

Easter Seals Services:

All Kids
Child Care Centers
School Readiness Program

Employment Industries

Center for Better Hearing

Birth to Three Program

Outpatient Medical Rehabilitation and Mobility Center

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Loraine C. Shea

Commission on Accreditation of Rehabilitation Facilities

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Marco Verga, MD
134 Grandview Ave
Waterbury, CT 06708
April 14, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr Hawes and Mr Lazarus,

I am a physician working in the Radiology Department at Waterbury Hospital and am writing this letter in support of the proposed transaction between Waterbury Hospital/Greater Waterbury Health Network and Prospect Medical Holdings. Waterbury Hospital has had a longstanding tradition of delivering outstanding medical care to the people of our community. This transaction will allow our hospital to better navigate the present and future challenges to the national and local healthcare landscape. It will help preserve the high quality delivery of health care that the people of our community deserve. Prospect brings essential capital to support and enhance infrastructure as well as improve the hospital's financial viability through cost sharing, economy of scale and investment.

As a physician practicing in this community for the last 15 years, I am confident that this transaction will bring great benefits to patients and the Waterbury community as a whole. I respectfully ask for your support in approving this transaction.

Sincerely,

Marco Verga, MD
Executive Managing Member
Diagnostic Radiology Associates

April 16, 2016

Mr. Gary Hawes
Assistant Attorney General
Office of the Attorney General

Mr. Steven Lazarus
Associate Health Care analyst
Department of Public Health
Office of Health Care Access

Dear Sirs:

As a past Board Member and past Chairman of Waterbury Hospital and the Greater Waterbury Health Network, I am acutely aware of the financial fragility of the hospital system in Waterbury. Waterbury Hospital has been able to maintain a high quality of health care in the absence of needed capital expenditures by virtue of the hard work and dedication of its staff. However, in my view it is questionable how much longer the high quality of health care currently provided by the hospital can be maintained without significant capital investment.

The pace of technical development in the health care industry requires investment in new technology in the form of equipment and the hiring of physicians to bring the next generation of health care to the hospital. In addition, existing equipment and facilities require upgrading in order to adequately meet current and future demand for health care. Without these investments, the quality of care and scope of services will gradually be eroded until we have a second rate health care system in Waterbury.

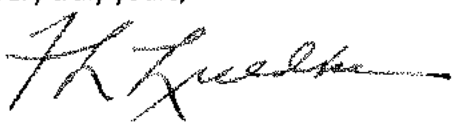
Given the high percentage of Waterbury Hospital's revenue coming from Medicaid and Medicare, there is insufficient surplus available to fund these necessary investments. That is why the acquisition of the Greater Waterbury health Network and Waterbury Hospital by Prospect Medical Holdings is so crucial to the future of health care in Waterbury. A company like Prospect has the capability to tap the capital markets to provide funding for these essential investments in the future.

As an argument for maintaining the status quo, some have claimed that a for-profit hospital can only survive by curtailing services and compromising quality. Ironically, that is precisely what will eventually happen if we do maintain the status quo.

Suggesting that a profit-seeking enterprise that is intent on growing its business would proceed in such a manner is ludicrous. Why would an organization seeking to grow in volume and revenue embark on a path of alienating its customers and reducing the services it offers? To the contrary, it would be incentivized to delight its customers, both patients and doctors, by providing expanded, high quality services so that they would be motivated to use the hospital and recommend it to others.

After careful consideration, I am convinced that the future of healthcare in Waterbury depends on this acquisition, and I urge you to approve it without further delay.

Very truly yours,



Frederick L. Luedke

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes and Mr. Lazarus:

My Name is Ernesto A. Cerdena, Director of Radiology and Laboratory Services at Waterbury Hospital. I am writing this letter in support of the transactions between Prospect Medical Holdings and Greater Waterbury Health Network. The current transformational healthcare climate calls for partnership that is more transformational. I firmly believe that the partnership between PMH and GWHN will do as that to achieve wellness in our population and improve the health of the community it serves. Thank you.

Sincerely,

Ernesto A. Cerdena

TORRCO™

100 North Elm Street, Waterbury, CT 06702
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April 18, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office Health Care Access

Dear Sir,

I am writing to strongly support the proposed acquisition of Waterbury Hospital/Greater Waterbury Health Network by Prospect Medical Holdings.

I have 3 strong bonds with GWHN, first as the CEO of one of Waterbury's larger employers (150 FTE's), second as a GWHN member, and third as a former board chair of GWHN.

Waterbury Hospital needs a strong partner to survive. Those of us in the business community watch in shock as the operating losses mount year after year and federal and state assistance declines. As an employer it is extremely important that Waterbury has a vibrant medical community and health system. That requires a prosperous and progressive hospital with the latest medical technology and equipment that will attract the best medical professionals. We have been lucky so far but that will not last forever. As the hospital delays infrastructure upgrades, the newest medical equipment, and latest technology, the best doctors will eventually leave Waterbury for medical centers of excellence in New Haven, Danbury, and Hartford. As citizen of Waterbury and employer, that is something we cannot allow to happen.

Thank you,

Joel Becker, CEO
Torrco

Phyllis C. DeLeo, Ph.D.
85 Center Street
Wolcott, CT 06716

April 19, 2016

Mr. Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Lazarus,

I am writing to express my support of the prospective affiliation of Waterbury Hospital/Greater Waterbury Health network with Prospect Medical Holdings. In my opinion, and that of many colleagues, this affiliation will not only serve the best interests of the hospital, but will undoubtedly help the hospital to better address the needs of our community as well.

Having formerly served on Waterbury Hospital's Board of Directors for more than a decade and, as a Greater Waterbury Health Network member now, I have had a peripheral—though keen--appreciation of the many challenges the hospital has faced and successfully managed to overcome over time. Yet, through the years, the institution has remained true to its mission, charting a steady course in an effort to provide the best possible healthcare for its patients, to play a significant role in the community at large, and to provide the support and resources required for its medical and professional staff.

Yes despite the hospital's myriad achievements, I firmly believe the challenges of the past twenty years are seeming precursors of even greater challenges and changes yet to come. And, indeed, these will indubitably be compounded by demographic changes as well as technological advancements which are essential to the escalating needs and currency of service the hospital will be called upon to provide.

I, therefore, ask that you lend your support to the Hospital's proposed transition with Prospect Medical Holdings so that it may access the structural resources and financial support required to sustain and, hopefully, improve upon the Hospital's delivery of stellar services to the community and the State. Thank you for your consideration of and attention to this imperative need.

Sincerely,

Phyllis C. DeLeo

Phyllis C. DeLeo, Ph.D.

Phyllis C. DeLeo, Ph.D.
85 Center Street
Wolcott, CT 06716

April 19, 2016

The Honorable Gary Hawes
Assistant Attorney General
Office of the Attorney General

Dear Attorney Hawes,

I am writing to express my support of the prospective affiliation of Waterbury Hospital/Greater Waterbury Health network with Prospect Medical Holdings. In my opinion, and that of many colleagues, this affiliation will not only serve the best interests of the hospital, but will undoubtedly help the hospital to better address the needs of our community as well.

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Sincerely,

Phyllis C. DeLeo

Phyllis C. DeLeo, Ph.D.

48 Idleview Drive
PO Box 489
Naugatuck, CT 06770

April 15, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Gary Hawes and Steven Lazarus:

Thank you for the opportunity to write to you in support of the proposed joint venture between Waterbury Hospital and Prospect Medical Holdings.

I have been employed with Waterbury Hospital since March of 2008. I am the Administrative Assistant for Plant Engineering. I am aware of the upkeep of such a facility.

I support the joint venture because we will then be able to make the necessary renovations and upgrades that are needed. We would also be able to purchase and provide state-of-the-art healthcare services to our community. The venture would provide substantial tax revenue for the city of Waterbury and the State of Connecticut.

Thank you for your consideration. I am hoping to continue working at Waterbury Hospital for many years to come. This partnership will benefit my family, the patients and the community.

Sincerely,

Judy Sabolchik
Administrative Assistant
Plant Engineering
Waterbury Hospital

Lori Dossantos

Gary Hawes

Assistant Attorney General

Office of the Attorney General

Steven Lazarus

Associate Health Care Analyst

Department of Public Health

Office of Health Care Access

April 19, 2016

Dear Sirs:

I have lived in the Greater Waterbury area for my entire 51 years. I am a single working-mother who has raised two responsible teenagers, and at the same time caring for my two elderly parents who also live in my home. My family has had more than one occasion where a trip to the emergency room was a necessity. On a number of those trips, the health care professionals at Waterbury Hospital saved my elderly father's life. I cannot count how many times we have used the services provided by Waterbury Hospital for an emergency, a surgical procedure, or routine testing. It would be hard to imagine the Greater Waterbury community without access to the professional services Waterbury Hospital provides to our community.

I want to definitively state that I completely support the proposed transaction between GWHN and Prospect Medical Holdings. The continued operation of Waterbury Hospital is vital to Waterbury and its surrounding towns. Let's not under estimate how the conclusion of this transaction will enable GWHN to continue to provide accessible, high quality health care services to our community for generations to come.

Kindest Regards,

Lori DosSantos

23 Woodvine Avenue

Oakville, CT 06779

Gary Hawes

Assistant Attorney General

Office of Attorney General

Steven Lazarus

Associate Health Care Analyst

Department of Public Health

Office of Health Care Access

Mr. Hawes and Mr. Lazarus,

My name is Michele Valentino. I am a Registered Physical Therapist and the Director of Rehabilitation Services at Waterbury Hospital. I have worked at Waterbury Hospital for more than 24 years. I started my career here as a Physical Therapy Aide in 1988 and when I graduated from college in 1992, my 1st choice for a place to start my career was Waterbury Hospital. I came to work in the capacity of staff Physical Therapist. After 7 years I became the Director of Rehabilitation Services. I have been doing that job and loving it ever since! I have treated patients from all walks of life, from many different ethnic and religious backgrounds and patients from all levels of socioeconomic status; who rely on our hospital to provide high quality and accessible healthcare.

I am writing to you in support of the proposed transaction of Waterbury Hospital/ GWHN with Prospect Medical Holdings. By combining forces with Prospect, GWHN can provide an excellent opportunity for our community to have improved healthcare resources, better facilities and state of the art medical technology which the Waterbury community has been lacking for many years. Prospect has ownership other hospitals and facilities in many cities and towns across the country including Rhode Island and they have provided all of those communities with excellent care for all who need it. In fact I believe they have made the Healthcare for those areas better by providing resources to communities that could not have afforded without Prospect's help.

As a member of this community, a healthcare consumer as well as a healthcare provider caring for our patients, I urge you to support the proposed transaction of Waterbury Hospital with Prospect Medical Holdings. It will help us to sustain excellent, reliable, high quality and state of the art healthcare for the Waterbury Community and beyond.

Please feel free to contact me with any questions or concerns. Thank you for your time and consideration in this matter.

Sincerely,

Michele Valentino

Director of Rehabilitation Services, Waterbury Hospital #203-573-6041

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Date: April 13, 2016

Dear Honorable Gary Hawes and Steven Lazarus

I'm proud to state that I have been an employee affiliated with Waterbury Hospital since 1974 and I'm proud to have been engaged in the development and oversight of many departments including the Greater Waterbury Health Network. My current position as Executive Director of Cardiology Associates of Greater Waterbury, LLC, a wholly owned subsidiary of Waterbury Hospital, has been extremely rewarding however has clearly demonstrated to me that the future success of the local health system goes beyond the boundaries of the communities that we serve. Our goals and objectives as an organization including the delivery of high quality care to our patients will only be achieved by choosing a partner with a similar mission who offers support from an operational and financial perspective as we meet our challenges head on. I truly believe that Prospect Medical Holdings is totally committed to Waterbury Hospital and its affiliate organizations and will be an excellent partner, engaged and enthusiastic and most importantly focused on the well being of our patients. Their leadership and guidance has been clearly demonstrated in other areas of the country and has certainly resulted in short and long term success.

Sincerely,

Jan Kennedy
Executive Director, Cardiology Associates of Greater Waterbury, LLC

April 12, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Attorney Hawes and Mr. Lazarus:

My name is John Michaels. Over the last 25 years I have been privileged to serve as a member, committee member, and past chairmen of the Waterbury Hospital and Greater Waterbury Health Network Board of Directors. And, I have been very involved in this community and have an in-depth understanding of its needs.

I have seen the outstanding quality of the care we give and the pressures put on our financial position from payers and governments. It is only through the economies of scale that come with consolidation that will enable hospitals our size to survive in the long term. Our financial deterioration over the last 10 years has proven that. World-class medicine at the local level can only be maintained when hospitals have access to capital to attract world-class physicians and invest in cost effective, cutting edge, life-saving technology. Operating margins for small institutions deny access to that capital.

Our acquisition by the Prospect group is an absolute necessity if we are to be able to provide that world-class care which our citizens deserve and need. It is only through the economies that come with being part of a larger group that we will be to continue to provide exemplary care for our patients It is essential that this transaction be fulfilled as planned.

I urge you to look favorably on and approve this transaction.

Thank you for your consideration.

Sincerely,

John Michaels

Amy Baldwin-Stephens
82 Van Orman Street
Oakville, CT 06779

April 11, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Dear Mr. Hawes,

I write this letter in support of the pending transaction between the Greater Waterbury Health Network and Prospect Medical Holdings in their efforts to enter into a business agreement in the city of Waterbury.

I am an employee of the Greater Waterbury Health Network, a consumer of their healthcare services and a member of the community. I am employed as the cancer registrar and can attest to the valuable care and services currently offered to cancer patients within the community and surrounding areas.

The Greater Waterbury Health Network has always been a pillar in this community for offering quality healthcare close to home. As a member of this community, the transaction with Prospect Medical Holdings will not only allow the Greater Waterbury Health Network to continue offering quality healthcare services but will also allow the Greater Waterbury Health Network to keep up with current healthcare trends and afford the opportunity to offer new services to the community and surrounding areas.

Sincerely,

Amy Baldwin-Stephens

Amy Baldwin-Stephens
82 Van Orman Street
Oakville, CT 06779

April 11, 2016

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Lazarus

I write this letter in support of the pending transaction between the Greater Waterbury Health Network and Prospect Medical Holdings in their efforts to enter into a business agreement in the city of Waterbury.

I am an employee of the Greater Waterbury Health Network, a consumer of their healthcare services and a member of the community. I am employed as the cancer registrar and can attest to the valuable care and services currently offered to cancer patients within the community and surrounding areas.

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Sincerely,

Amy Baldwin-Stephens

Sean P. Payne
25 Courtney Court
Meriden, CT 06450
April 11, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Gary Hawes:

I am an employee of Waterbury Hospital /Greater Waterbury Health Network (GWHN) and I am writing in support of the proposed transaction between GWHN and Prospect Medical Holdings. I serve as a Health Systems Administrator for Health Information Management and I am excited and looking forward to the positive benefits this transaction is sure to bring the community of Waterbury, and the employees & medical staff at Waterbury Hospital.

The city of Waterbury, along with its neighboring communities, is long overdue for an event of this measure that will likely stimulate the transformation of healthcare in our region. The employees and clinical staff at Waterbury Hospital are extremely proud of the things that have been achieved over its 125 years of service and we know Prospect Medical Holdings will only aide in our mission as they share in our ideals and our long-standing commitment to quality care for our patients. While I understand that a public hearing (which is now scheduled for May 3rd) is an important step in this process, I hope you will continue to listen carefully to the caring testimonies of our delegates and respond favorably in the interest of those that really matter the most – our patients.

Thanks in advance for taking the time to hear what we have to say and for supporting this proposed transaction between GWHN and Prospect Medical Holdings!

Sincerely,

Sean P. Payne

To: Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

My name is Brian Emerick and I am the President for Access Rehab Centers, which is a local rehabilitation company that is a partnership between Waterbury Hospital and Easter Seals of Greater Waterbury.

I would first like to thank you for the opportunity to share some thoughts regarding the proposed acquisition of Waterbury Hospital by Prospect Medical Holdings.

I would respectfully ask that, when considering this transaction that we need to take into consideration, not just the history of Waterbury Hospital or even what the current state of healthcare is in this community ...I would suggest that we need to consider where we are going in the "big picture" for healthcare and what that means for the survival of all healthcare facilities going forward.

There are big changes in healthcare that are going on right now. Those changes will lead to major challenges to the survival of hospitals, independent practices, and many of the traditional institutions that we have all taken for granted as being our traditional healthcare system.

Everyone knows that Hospitals are struggling under reduced reimbursements as well as a significantly larger number of people who require services.

There are several major trends that are impacting almost all of the Hospitals in CT...one of the most significant is that healthcare is moving more towards preventing sickness and maintaining health. One of the key changes to make that happen is treating people in their home or in the least costly location. That means that the definition of "success" for a Hospital is changing from providing the best care possible to as many people as possible..to a point in the future where the definition of success will be "supporting health for all people in the community, preventing sickness and preventing the need for hospitalizations". There is one serious flaw in the process for the average Hospital; when a hospital does not have the community based resources available to create that healthier community then they will not be able to achieve the results that they will be expected to achieve and as reimbursements continue to go down for hospitalizations, those hospitals that cannot provide a more robust outpatient network will eventually be forced to close. In the future, Hospitals will be paid to keep people healthy and each hospital will be expected to absorb more and more of the costs for individuals who eventually do require hospitalizations.

I have worked with Waterbury Hospital for over 16 years and I can honestly say that the care at Waterbury Hospital today is the best that I have ever seen it be in those 16 years. It is of a higher quality and it is provided with a significantly higher degree of efficiency as well. Even with all of those positive changes I can say that the expectations that are on a Hospital today make it extremely hard to provide care and keep the doors open. How many of the business owners in a community could stay open if

there were an increasing number of people walking through their doors that were only required to pay below cost for the goods that they purchase? This is an easy equation.....if more people pay below costs for your goods or services, you have to make up the difference on the other customers that walk through the door or your will be out of business. You either increase your prices (which Hospitals are no longer able to effectively accomplish) or you decrease your costs. CT Hospitals can only go through so many rounds of layoffs before they run out of options. We have already seen all of the area Hospitals do many rounds of layoffs and I would say that many CT Hospitals will continue to have to make those same tough choices.

So why Prospect? As I see it, there are two primary reasons: the first is that Prospect brings to the table the expertise and the connections to assist in reducing expenses even further. By bringing in large purchasing agreements to reduce supply costs and by bringing additional ideas for new ways to do best practices and reduce inefficiencies and redundancies....ideally we can streamline the system without having to cut into staffing and quality.

The second reason is the biggest reason of all: Prospect brings the capital that Waterbury Hospital will require to adapt itself to the new demands of Healthcare and be able to survive. I would anticipate that, with adequate funds, Waterbury Hospital will continue to develop services integrated into the surrounding communities so that healthcare is available in a much more efficient and easily accessible manner so that folks in the community will be able to access health care quicker, maintain their health and prevent costly hospitalizations.

I have looked at the Prospect system and it is obvious that they know what they are doing. They know how to decrease costs and run efficient Hospitals. That means that not only do their Hospitals provide the healthcare and the jobs that the community needs but they also have the capital to be able to adapt and grow rather than just reel from one fiscal challenge to the next. Prospect brings with it the expertise to maneuver healthcare systems into a more efficient and high quality system that will be sustainable, viable and strong, going into the future.

Thank you.

Brian P. Emerick, MSOT,MBA
President
Access Rehab Centers, LLC
bemerick@accessrehabcenters.com
(203) 419-0381 ext. 222

Joanne M. Seymour, M.S., N.C.C., L.P.C.
41 Aron Avenue, Waterbury, CT 06708 203-910-4609

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

April 11, 2016

Dear Mr. Hawes and Mr. Lazarus:

My name is Joanne Seymour. I recently celebrated my 22nd anniversary at Waterbury Hospital, specifically in the Behavioral Health Department. I have worked in the Crisis/ Behavioral Health Emergency Room, Inpatient Behavioral Health and Outpatient Behavioral Health, in both Managerial and Clinical (or combined) positions.

In the 22 years I have been employed at the hospital, I have seen a number of restructuring efforts and cuts, as well as managed insurances and universal health insurance expand; none of the efforts do more than put a Band-Aid on the situation. Resources continue to be cut, and day to day, our jobs have become more difficult as we try to treat very challenging individuals on the inpatient unit and in the community.

I support the proposed transaction between GWHN and Prospect Medical Holdings because I hope that this transaction will help our hospital obtain needed capital to address a deteriorating physical plant and expand our services that bring in income. We need a positive change. We need to make sure we can provide excellent patient care and that Prospect can give us efficiencies in resources and costs. Clearly, the hospital will not survive without the new direction that Prospect can provide.

Sincerely,

Joanne M. Seymour, MS, NCC, LPC

Joanne M. Seymour, M.S., N.C.C., L. P. C.
Nationally Certified Counselor, Licensed Professional Counselor

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Sirs:

I am a longtime employee of Waterbury Hospital. I will be here 29 years in August. I truly feel that we give better care because we care about our patients. This organization needs to continue to do this and with the help of Prospect Medical Holding we have a chance to maintain the excellent patient care we are known for. I have seen such a change here in the past 5 years and it has all been good changes. The Waterbury area needs us to keep up that momentum and carry it through. I believe we have what it takes and with Darlene Stromstad & Prospect leading the way we cannot lose. Please support this transaction as we do here at the hospital.

Monica Doyle

Monica Doyle
Asst Mgr Customer Support
IT Department
Waterbury Hospital
203-573-7543
mdoyle@wtbyhosp.org

WATERBURY HOSPITAL

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Sirs,

I am writing to you in support of the Joint Venture between Waterbury Hospital and Prospect Medical Holdings.

I came to Waterbury Hospital as the Chairman of the Department of Surgery eleven years ago. I had been practicing at the University of Connecticut Health Center since 1990. I trained at major University Hospitals as well as the National Cancer Institute and Memorial Sloan Kettering Cancer Center. My duties at Waterbury Hospital include Chairing the Department of Surgery and overseeing the General Surgery Residency Program.

Waterbury Hospital provides greatly needed services to the citizens of Waterbury and the surrounding communities. We are a Level II Trauma Center and care for patients with a variety of urgent and non-urgent health care needs. Many of our patients are uninsured or underinsured which makes "balancing the books" challenging. We manage to provide excellent care with limited resources.

Without the backing of a larger partner in the current health care economic environment, medium sized hospitals such as ours cannot survive much longer. The Joint Venture will allow us to continue to provide these much needed services to our patients. I urge you to keep the needs of the patients and the many dedicated employees in mind when considering the pros and cons of converting to a for profit model. Personally, I am confident that Waterbury Hospital will continue to be Waterbury Hospital and provide care to the same people who we treat now. We will have financial resources that will ensure our survival, allow us to update our equipment and fulfill our continued mission.

Thank you for allowing me to share my thoughts on this important issue.

Signed,

Scott H. Kurtzman, MD FACS
Chairman of Surgery
Program Director General Surgery Residency

Professor of Surgery
University of Connecticut School of Medicine

Professor of Surgery
Frank Netter School of Medicine
Quinnipiac University

April 11, 2016

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes:

My name is Josie Soucy and I am a nurse at Waterbury Hospital. My present position is, director of medical/surgical nursing and I have been employed by Waterbury Hospital for 3 ½ months.

I am writing this letter in support of the proposed transaction between GWHN and Prospect Medical Holdings. As with other hospitals in the State of Connecticut, Waterbury is in need of funds to help with capital acquisition and physical plant infra-structure renovations. In light of the payer source, Waterbury Hospital would not be able to survive without a strong acquisition supporting its daily operations.

Waterbury is a busy inner city hospital with an average daily census of 150 or better. The staff here care about the patients and the care they are given. Without Waterbury Hospital, where would these patients go for care?

I ask you to support the proposed transaction between GWHN and Prospect Medical Holdings. Thank you in advance.

Josie Soucy, MSN,RN,CCRN,NE-BC
Director, Medical/Surgical Nursing
Waterbury Hospital

April 11, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Dear Mr. Hawes:

My name is Josie Soucy and I am a nurse at Waterbury Hospital. My present position is, director of medical/surgical nursing and I have been employed by Waterbury Hospital for 3 ½ months.

I am writing this letter in support of the proposed transaction between GWHN and Prospect Medical Holdings. As with other hospitals in the State of Connecticut, Waterbury is in need of funds to help with capital acquisition and physical plant infra-structure renovations. In light of the payer source, Waterbury Hospital would not be able to survive without a strong acquisition supporting its daily operations.

Waterbury is a busy inner city hospital with an average daily census of 150 or better. The staff here care about the patients and the care they are given. Without Waterbury Hospital, where would these patients go for care?

I ask you to support the proposed transaction between GWHN and Prospect Medical Holdings. Thank you in advance.

Josie Soucy, MSN,RN,CCRN,NE-BC
Director, Medical/Surgical Nursing
Waterbury Hospital

DIAGNOSTIC RADIOLOGY ASSOCIATES
Trusted Care Since 1974

Women's Imaging Center

Kenneth Allen, M.D. | John DeLeon, M.D. | Justin Champagne, PA-C
Duncan Belcher, M.D. | Eric Hyson, M.D. | Daniel DeJesus, PA-C
Stewart Berliner, M.D. | Andrew Lawson, M.D. | Ross Utter, PA-C
Anthony Carter, M.D. | Marco Verga, M.D.

April 21, 2016

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106

Dear Sir,

My name is Duncan J. Belcher, MD, and I am a radiologist at Waterbury Hospital. I have worked at Waterbury Hospital for 19 years and am currently the elected Chief of the Department of Radiology. I am writing this letter in support of the proposed transaction between Greater Waterbury Health Network and Prospect Medical Holdings. In the years that I have worked at Waterbury Hospital, I have seen firsthand the difficulty the hospital faces financially in the current medical reimbursement environment. I have met individuals from Prospect Medical Holdings and feel strongly that this organization will be a very good merger partner and provide the hospital the financial backing it needs to move forward in the future for the community of Waterbury. As a radiologist, I practice in a specialty that is dependent on investment in technology to provide the best care possible to our patients. I feel it is imperative that our hospital be allowed to move forward with this transaction so that we can continue providing state-of-the-art care that our community deserves.

Thank you for attention to this matter.

Sincerely,

Duncan J. Belcher, MD
Elected Chief, Department of Radiology, Waterbury Hospital
Managing Partner, Diagnostic Radiology Associates, Waterbury, CT

DJB/ksb

Waterbury
Medical Arts Building
134 Grandview Avenue, Suite 101 • Waterbury, CT 06708
203-756-8911 • Fax 203-574-3298 • DRAxray.com

Southbury
32 Poverty Road • Suite B & C
Southbury, CT 06488
203-262-6797 • Fax 203-262-6006 • DRAxray.com

Middlebury
Turnpike Office Park
1579 Straits Turnpike • Middlebury, CT 06762
203-758-2588 • Fax 203-758-2599 • DRAxray.com

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Anthony Carter, M.D. | Marco Verga, M.D.

April 21, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

Dear Sir,

My name is Duncan J. Belcher, MD, and I am a radiologist at Waterbury Hospital. I have worked at Waterbury Hospital for 19 years and am currently the elected Chief of the Department of Radiology. I am writing this letter in support of the proposed transaction between Greater Waterbury Health Network and Prospect Medical Holdings. In the years that I have worked at Waterbury Hospital, I have seen firsthand the difficulty the hospital faces financially in the current medical reimbursement environment. I have met individuals from Prospect Medical Holdings and feel strongly that this organization will be a very good merger partner and provide the hospital the financial backing it needs to move forward in the future for the community of Waterbury. As a radiologist, I practice in a specialty that is dependent on investment in technology to provide the best care possible to our patients. I feel it is imperative that our hospital be allowed to move forward with this transaction so that we can continue providing state-of-the-art care that our community deserves.

Thank you for attention to this matter.

Sincerely,

Duncan J. Belcher, MD
Elected Chief, Department of Radiology, Waterbury Hospital
Managing Partner, Diagnostic Radiology Associates, Waterbury, CT

DJB/ksb

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203-758-2588 • Fax 203-758-2599 • DRAxray.com

WATERBURY HOSPITAL

David N. Podell, M.D., Ph.D., FACP, FACR
Firm Chief, Department of Medicine
(203) 573-7194

Clinical Professor of Medicine
Yale University School of Medicine

April 22, 2016

Mr. Gary Hawes
Assistant Attorney General
Office of the Attorney General

Mr. Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes and Mr. Lazarus:

It gives me great pleasure to enthusiastically endorse and support Waterbury Hospital and Prospect Medical Holdings proposed transition. I have been a member of the medical staff for over 27 years and have dedicated my career to patient care and medical education in the greater Waterbury community.

Waterbury is my home and I strongly feel that this transition will allow Waterbury Hospital to be the preeminent provider for healthcare in Waterbury for the future. Healthcare has many challenges in terms of providing quality care at acceptable cost. In addition, Waterbury has great challenges in providing care for the underserved. In working with Prospect Medical Holdings, I have been so impressed by their superb abilities to provide quality care to all members of the community. They have proven this in the hospitals that they have worked with across the United States. In working with members of Prospect Holdings I find them to be extremely knowledgeable and dedicated for the success of this hospital. It will provide greater care and I am very excited about the future plans for this transaction.

Thank you for the opportunity to share this information with you.

Very truly yours,

David N. Podell, M.D., Ph.D., MACP, FACR
Chairman,
Department of Medicine
Waterbury Hospital

Clinical Professor of Medicine
Yale University School of Medicine

DNP/rte

Kimberley J. Paternostro
47 Brackenridge Drive
Waterbury, CT 06706

February 11, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Re: Proposed Joint Venture between Waterbury Hospital and Prospect Medical Holdings

Dear Attorney Hawes;

I am proud to say I have been an employee of Waterbury hospital for the past 19 years. I am the Operations Manager for The Health Information Management Department. My family and friends have been fortunate to have been treated at Waterbury Hospital where there are such caring and highly qualified healthcare professionals. Our hope is with this acquisition we will be able to provide the same great care in the present and future that we have provided in the past. The economy has presented us with a dilemma in regards to financial stability therefore making this move into the future tenuous at best.

We need to be able to move along with the times and offer our patients the best care possible which quite frankly will be very difficult without the resources to purchase new state of the art equipment as well as attracting and retaining highly qualified healthcare professionals.

Prospect Medical Holdings will be able to provide Waterbury Hospital with the tools we need to survive and thrive in this ever changing environment.

Our hopes are that you will be able to look into the future **now** and afford us the opportunity to say" Waterbury Hospital where caring makes a world of difference yesterday, today and tomorrow".

Thank you,

_____
Kim Paternostro

1067 Wolf Hill Road
Cheshire, CT 06410
April 11, 2016

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

Dear Mr. Hawes and Mr. Lazarus:

I am writing in support of the proposed transaction between Waterbury Hospital and Prospect Medical Holdings. The transaction is necessary in order to provide the capital to allow Waterbury Hospital to continue to provide a high level of care to our local residents.

I first came to Waterbury Hospital for my internship year in 1975-76, as part of my radiology residency at Yale. Since completion of my residency in 1979, I have been a practicing radiologist at Waterbury Hospital. The reason I came back to Waterbury Hospital is the quality of the physicians and other caregivers here, and the quality of care that we give to our patients. As residents of Cheshire, my wife and I have been patients ourselves at the Hospital and want to continue to rely on it as "our hospital" when we need care in the future. Capital investment is necessary to continue to provide the best available medical equipment and healing environment. I have faith in the Hospital administration, and agree with them that the transaction is the right decision for Waterbury Hospital and our patients.

The community needs a financially healthy Waterbury Hospital, and the transaction with Prospect would go a long way toward realizing that goal. Please do what you can to allow this to happen. I appreciate your consideration.

Sincerely,

Eric A. Hyson

Eric A. Hyson, MD

WATERBURY HOSPITAL

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Steven Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
February 24th, 2016

Mr. Hawes and Mr. Lazarus:

Hello, my name is Aaron Burton and I am the Director of Pharmacy at Waterbury Hospital. I have served in my current role for four months and am very excited to voice my support for the proposed transaction between GWHN and Prospect Medical Holdings. The potential this transaction brings to improve patient care for the members of the Waterbury community was a key component of my acceptance of my role at Waterbury Hospital. I had previously worked at Warren Hospital, a small community hospital in New Jersey, which had merged with a larger organization recently. The ability of the parent company in this situation, St. Luke's University Health Network, to work closely as a partner with Warren Hospital dramatically improved the quality of care provided to that community. I am certain the Waterbury, Connecticut community would receive a similar benefit from the proposed transaction with Prospect Medical Holdings.

I think this transaction is imperative to providing the highest quality of care to the patients of the Waterbury community. Please feel free to reach out to me if you have any additional questions that would further substantiate my support for this transaction.

Sincerely,

Aaron Burton
Director of Pharmacy
Waterbury Hospital
64 Robbins Street
Waterbury, CT 06708
Office phone: 203-573-6040
Email: aburton1@wtbyhosp.org

Olejarz, Barbara

From: Anne D. Peterson <APeterson@carmodylaw.com>
Sent: Monday, May 02, 2016 3:47 PM
To: Lazarus, Steven; Michele Volpe (mmv@bvmlaw.com); Ann H. Zucker; Kristin Connors; Kathleen Gedney; Jennifer O'Donnell
Cc: Hawes, Gary W.; Martone, Kim; Greer, Leslie; Hansted, Kevin; Olejarz, Barbara
Subject: RE: Draft Table of the Record and Tentative Agenda- DNs: 15-32017-486 and 15-486-02

Hi Steve – we have received many letters of support for the project over the past few days. Would you prefer that I email them to you this afternoon, or should we bring copies to the hearing tomorrow? Many thanks.

Anne

Anne D. Peterson | Bio
Carmody Torrance Sandak & Hennessey LLP
195 Church Street | P.O. Box 1950
New Haven, CT 06509-1950
Direct: 203-784-3104 | Fax: 203-784-3199
APeterson@carmodylaw.com | www.carmodylaw.com

From: Lazarus, Steven [mailto:Steven.Lazarus@ct.gov]
Sent: Monday, May 02, 2016 2:58 PM
To: Michele Volpe (mmv@bvmlaw.com); Ann H. Zucker; Kristin Connors; Anne D. Peterson; Kathleen Gedney; Jennifer O'Donnell
Cc: Hawes, Gary W.; Martone, Kim; Greer, Leslie; Hansted, Kevin; Olejarz, Barbara
Subject: Draft Table of the Record and Tentative Agenda- DNs: 15-32017-486 and 15-486-02

Please see the attached tentative agenda and the table of the record for tomorrow's public hearing in the matter referenced above. Any questions, please feel free to contact Gary (at gary.hawes@ct.gov) or myself.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Department of Public Health
Office of Healthcare Access
410 Capital Avenue
Hartford, CT 06106

Dear Ms. Davis:

I first came to Waterbury Hospital with the belief that Tenet Healthcare would be taking over and guiding the strategic planning for the future of the hospital. It was such a different time then and it seemed as if we were making wise decisions and moving in the right direction. But from the very moment Tenet pulled out, the hospital has been in a downward spiral without real direction. Chaos and continuous knee-jerk reactions reign supreme! Everyone is just grabbing at straws and attempting to make a quick buck and get by and not worry about the overall future of the hospital. Of all the potential "deals" that have come along, this Prospect Medical Holdings is by far the worse and the "lowest" as far as respectability and decency are concerned. I am actively looking to leave more for conscientious reasons than anything else, but once you are at a certain level and do not wish to re-locate the job choices are more limited. Claiming to be highly transparent, it is known to all who work here that talks take place behind closed doors where various and secret promises are made basically telling everyone what they want to hear -- similar to the carpet-baggers at the close of the silver war – "40 acres and a mule!" It would be such a travesty and disgrace, if this is the "deal" that the State of Connecticut allows to happen after all we have gone through striving for the right "deal" to best serve the needs of our community.

Thank you for your time!

[I actually am uncomfortable signing my name to this letter since I am not certain it will remain confidential]

StayWell Health Center
Growing a healthier community one person at a time

RECEIVED
JUN 20 2016
Office of
HEALTHCARE ACCESS

June 16, 2016

Mr. Steven Lazarus
Associate Health Care Analyst
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106

Dear Mr. Lazarus,

I write as a healthcare leader in the Waterbury community for the past 25 years and also a lifelong resident of the city of Waterbury. I have seen innumerable changes in the health care system throughout my professional career, some of which have stemmed from state and federal policy changes, but many that have been unique and in response to local decisions. While I continue to have confidence in the capabilities of my colleagues, the changes have not been without consequences to our community and StayWell Health Center.

In 2013, six community partners, including both hospitals and StayWell founded the Greater Waterbury Health Improvement Partnership. An extensive needs assessment was completed and was considered to be a guide for the community benefit planning for both hospital entities. As a community, we have come together and developed workgroups to address the priorities indicated in the assessment. With State budget challenges, increased operating costs, and changes in demographics, it is every more difficult to deliver services.

StayWell itself has had to expand due to formal and informal changes in programming and staffing by both hospitals and other entities over the past twenty years. Our organization is currently providing 90,000 patient visits annually, across nine sites in Waterbury. Unfortunately, there has been nominal if any funding to support such absorption of services and patients. Most recently, StayWell has had to assume the lead role for Part A Ryan White Region 2. There is a significant clinical and administrative burden that comes with this role.

I would strongly urge the State of Connecticut to consider the long term needs of the Waterbury community and the best stewards for securing the commitment and resources to meet those needs. As you are aware, community health centers are charged by the federal government and designed to be responsive to community needs combined with the benefit of extensive federal standards and oversight. Another strong and reputable local partner who could serve as a good steward of available funds following the hospital transaction is the Connecticut Community Foundation.

As the CEO of StayWell, I ask that you strongly consider that Waterbury Hospital establish an endowment fund at the Connecticut Community Foundation for StayWell and an additional fund to generate ongoing resources for community health initiatives. Thank you in advance for your consideration. I would be willing to provide further details of the specific needs in our community and the ways in which these funds could have an impact if properly secured for our community.

Respectfully Submitted,

Donald J. Thompson, MPS
President / CEO

Mark Briggs
Chairman of the Board of Directors

cc: Joan Hartley

Phone: 203.756.8021 Fax: 203.596.9038 www.staywellhealth.org

Our Centers
StayWell Health Center
80 Phoenix Avenue, Waterbury, CT 06702
StayWell South End Health Center I & II
1309 & 1302 South Main Street, Waterbury, CT 06706
Driggs School-Based Health Center
77 Woodlawn Terrace, Waterbury, CT 06710
Open Arms at St. Vincent DePaul Shelter
114 Benedict Street, Waterbury, CT 06706
Open Arms at Western CT Mental Health Network
95 Thomaston Avenue, Waterbury, CT 06702
Open Arms at Salvation Army Family Shelter
74 Central Avenue, Waterbury, CT 06702

Olejarz, Barbara

From: Lazarus, Steven
Sent: Monday, May 02, 2016 2:58 PM
To: Michele Volpe (mmv@bvmlaw.com); AZucker@carmodylaw.com; Kristin Connors; Anne D. Peterson; Kathleen Gedney; Jennifer O'Donnell
Cc: Hawes, Gary W.; Martone, Kim; Greer, Leslie; Hansted, Kevin; Olejarz, Barbara
Subject: Draft Table of the Record and Tentative Agenda- DNs: 15-32017-486 and 15-486-02
Attachments: 15-32017 agenda.doc; 32017 table.doc

Please see the attached tentative agenda and the table of the record for tomorrow's public hearing in the matter referenced above. Any questions, please feel free to contact Gary (at gary.hawes@ct.gov) or myself.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

Office of Health Care Access

TENTATIVE AGENDA

HEARING

Docket Number: 15-32017-486 and 15-486-02

Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC

Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.

May 3, 2016 at 1:00 p.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony**

III. **Public Comment**

IV. **OHCA's Questions**

V. **OAG's Questions**

VI. **Continuation of Public Comment**

VII. **Closing Remarks**

VIII. **Public Hearing Adjourned**

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL
Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC**

DOCKET NUMBER: **15-32017-486 and 15-486-02**

PUBLIC HEARINGS: **May 3, 2016 at 1:00pm**

PLACE: **Courtyard by Marriott Waterbury Downtown**
63 Grand Street
Waterbury, CT 06704

EXHIBIT	DESCRIPTION
A	Letter from Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC (Applicants) dated July 17, 2015 enclosing a Determination form for the proposal to transfer certain of its assets to Prospect Medical Holdings, Inc., received by the Office of Health Care Access (OHCA) on July 17, 2015. Also and Notice of Appearance was received from Bershtein, Volpe & McKeon P.C on behalf of the Applicants in the matter of the Certificate of Need (CON) under Docket Number OHCA15-32017-486 and OAG15-486-02 (10 pages)
B	Office of the Attorney General (OAG) and Office of Health Care Access' (OHCA) letter to the Applicants dated August 6, 2015 determining that approval is required pursuant to Conn. Gen. Stat. §19a-486 et seq. (16 pages)
C	Letter from the Applicants to OHCA and OAG dated October 2, 2016 r equesting a thirty day time extension for the submission of the CON application in the matter of the Certificate of Need (CON) under Docket Number OHCA15-32017-486 and OAG15-486-02, received by OHCA on October 2, 2015. (1 page)
D	OAG and OHCA letter to the Applicants dated October 2, 2015 approving the request for time extension in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02 (2 pages)

E	Letter from Applicants dated October 28, 2015 enclosing the Certificate of Need (CON) application for the proposal to transfer certain of its assets to Prospect Medical Holdings, in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02, received by OHCA on October 28, 2015. (1,408 pages)
F	OAG and OHCA letter to the Applicants dated November 17, 2015 requesting additional information and/or clarification in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02 (15 pages)
G	Designation letter dated December 16, 2015 of Hearing Officer in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02 (1page)
H	Applicants' responses to OAG and OHCA's letter of November 17, 2015 dated December 24, 2015, in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02 received by OHCA December 24, 2015 (46 pages)
I	OAG and OHCA letter to the Applicants dated January 12, 2016 requesting additional information and/or clarification in the matter of the CON application under docket Number OHCA15-32017-486 and OAG15-486-02 (5 pages)
J	OAG and OHCA letter to the Applicants dated January 20, 2016 enclosing an Order Regarding Admnistrative Notice in the matter of the CON application under docket Number OHCA15-32017-486 and OAG15-486-02 (1 page)
K	Applicants' responses to OAG and OHCA's letter of January 12, 2016 dated February 16, 2016, in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02 received by OHCA February 16, 2016. (56 pages)
L	OAG and OHCA letter dated March 4, 2016 to the Applicants deeming the application complete in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02 (1 page)
M	Petitions asking OHCA to hold the hearing at a convenient time other than the presidential primary day in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02, received by OHCA on April 4, 2016 (3 pages)
N	Letter from the public undated in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02, received by OHCA on April 4, 2016. (1 page)
O	OAG and OHCA request for legal notification in the *Republican American* Of OHCA's and OAG's Notice to the Applicants of the public hearing scheduled for May 3, 2016, in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. dated April 8, 2016 (4 pages)

P	OAG and OHCA letter to the Applicants dated April 13, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. (5 pages)
Q	Letter from Applicants dated April 26, 2016 requesting a time extension for filing the prefile testimony in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. Received by OHCA on April 26, 2016 (1 page)
R	OAG and OHCA letter to the Applicants dated April 26, 2016 approving the time extension matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. (1 page)
S	Letter from the Applicants enclosing Prefile Testimony and responses to issues in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. dated April 27, 2016, received by OHCA on April 27, 2016 (202 pages)

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL
Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC**

DOCKET NUMBER: **15-32017-486 and 15-486-02**

PUBLIC HEARINGS: **May 3, 2016 at 1:00pm**

PLACE: **Courtyard by Marriott Waterbury Downtown**
63 Grand Street
Waterbury, CT 06704

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B	Office of the Attorney General (OAG) and Office of Health Care Access' (OHCA) letter to the Applicants dated August 6, 2015 determining that approval is required pursuant to Conn. Gen. Stat. §19a-486 et seq. (16 pages)
C	Letter from the Applicants to OHCA and OAG dated October 2, 2016 r equesting a thirty day time extension for the submission of the CON application in the matter of the Certificate of Need (CON) under Docket Number OHCA15-32017-486 and OAG15-486-02, received by OHCA on October 2, 2015. (1 page)
D	OAG and OHCA letter to the Applicants dated October 2, 2015 approving the request for time extension in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02 (2 pages)

	OAG15-486-02. (5 pages)
P	Letter from Applicants dated April 26, 2016 requesting a time extension for filing the prefile testimony in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. Received by OHCA on April 26, 2016 (1 page)
Q	OAG and OHCA letter to the Applicants dated April 26, 2016 approving the time extension matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. (1 page)
R	Letter from the Applicants enclosing Prefile Testimony and responses to issues in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. dated April 27, 2016, received by OHCA on April 27, 2016 (202 pages)
S	Letter from the Applicants dated 5/2/16 enclosing support letters in the matter of the CON application under Docket Number OHCA15-32017-486 and OAG15-486-02. dated April 27, 2016, received by OHCA on May 2, 2016 (120 pages)

Sign in to speak during Public Comment period(s)

	Name	Organization	Contact info: Address, phone, and email
✓	Nicholas J. Coscia	Patient, Both Hospitals	CosciaNick@yahoo.com
✓	Kim Lukic	Patient community member	Klukic1@gmail.com 40 Lake St Wolcott, CT 203-525-1107
✓	Lynne Ide	Universal Health Care Foundation of CT	UHCF, 290 Pratt St., Meriden, CT 06450 203-639-0550 ext. 320 lide@universalhealthct.org
✓	David Pizzuto	Waterbury Hosp VP Public Affairs	1211 W. Main ST Waterbury CT 06708 dpizzuto@wtbyhosp.org
✓	Lester Schindel	Charter Care Health Partners	825 Chalkstone Ave Providence RI 02908 401-456-2084
✓	Nancy Rhodes	Waterbury Hosp Aux Inc	64 Sunrise Rd 2035794738 Wolcott CT 06716
✓	Lynn Ward	Waterbury Regional Chamber	lward@waterburychamber.com
✓	Philip Gveatin	Patient Waterbury Hospital	P.Gveat.n.29@gMail.com
✓	Jose Perez	CT Health Care Associates	jperez@chcaunion.org
✓	Dennis Yanavich	Waterbury Hospital	JYanavich@Gmail.com
✓	Jackie Roberts	waterbury Hospital	j.roberts2102@gmail.com
✓	Gerald Lewis	waterbury Hospital	popajoe456.gl526@gmail.com
✓ (*)	Joseph Geary	City of Waterbury	JJeary@waterbury CT.org

Sign in to speak during Question and Answer session

Name	Organization	Contact info: Address, phone, and email
~~Ann Scott~~	~~CT Citizen Action Group~~	
Rosana Garcia	Universal Health Care Foundation of CT	rgarcia@universalhealthct.org
Mike Webb	Waterbury Hospital/Nurses	MWebb@wtbyhosp.org
Valerie Celaj	Chase Outpatient	vcelaj@stfrancismed
~~[illegible]~~	~~Waterbury Hospital~~	~~[illegible]~~
Ronald D'Ambrosi	Patient	1260 Buckingham St Unit 502 Watertown CT 06795
Ann Marie Garrison	VNA Health at Home	agarrison@vnahealthathome.org
Neil Peterson	WHHC	npeterson@wtbyhosp.org
Earl Bueno	WHHC	ebueno@wtbyhosp.org
~~Brian P.~~ Brian P. Enerich	Access Rehab Centers	benerich@AccessRehabCenters.org
Neil Cullen		
James H. Gatling	NOI	jamesh.gatling@neoopportunitiesinc.org
Lorraine Shea	Easter Seals	lshea@eswct.com
[illegible]	WHO	[illegible]

Can he go second? needs to catch a flight?

(AHR) Galloway

Sign in to speak during Public Comment period(s)

	Name	Organization	Contact info: Address, phone, and email
26	William Pizzuto Ph.D.	UCONN/WTBY HOSPITAL	William.Pizzuto@UCONN.EDU
27	Michelle Diaz	Waterbury Hosp.	mdiaz@wtbyhosp.org
28	Addie Geary	Waterbury Hosp.	Ageary1009@yahoo.com
29	Patricia Kinzly	Waterbury Hospital	pkinzly@wtbyhosp.org
30	Brenda Keller	Waterbury Hospital	bkeller@wtbyhosp.org
31	James Rawlings	NAACP	203-215-1521
32	Graeme Jones	WH	GJones@wtbyhosp.org
33	Nicole Mannetti		203-560-7412
34	Paula Van Ness	CT Comm. Foundation	203-753-1315
38	Anthony J Cusano MD	Connecticut Valley Hospital	140 Grandview Ave 2035977933 Waterbury CT 06708 AJC2MD@AOL.COM
39	Ermelinda Bylykbashi	Waterbury Hospital	203 982 1788
	Steve Shrag		

Sign in to speak during Public Comment period(s)

Name	Organization	Contact info: Address, phone, and email
Steve Schrag	COMMUNITY UNITED	14 QUENTIN ST WTBY
Brenda Morisette	Community United	129 Adelaide Ave Wtby
John Thomason	Naugatuck Valley Project	2 Church St. Woodbury 06798 johnthomason1978@yahoo.com
Blair F. Bertaccini	AFSCME Chapter 4 Retirees	104 Fiske St Wtby CT 06710 203-574-0065 - actin1776@yahoo.com
Michele Valentino	Physical therapist	113 LOCKWOOD LN WTBY CT

Sign in to speak during Public Comment period(s)

Name	Organization	Contact info: Address, phone, and email
William Pizzuto Ph.D.	UConn/Wtby Hospital	William.Pizzuto@uconn.edu
Michelle Diaz	Waterbury Hosp.	mdiaz@wtbyhosp.org
Adaie Geary	Waterbury Hosp.	Ageary1009@yahoo.com
Patricia Kinzly	Waterbury Hospital	pkinzly@wtbyhosp.org
Brenda Keller	Watobury Hsptal	bkeller@wtbyhosp.org
James Bailey	NAACP	203-215-1521
Graene Jones	WH	GJonesQW7BYHOSP.ORG

Sign in to speak during Question and Answer session

Name	Organization	Contact info: Address, phone, and email
~~James Pawlings~~	~~NRAEP~~	~~203-215-1521~~
[redacted] Nicole Mannetti	Patient	203-560-7412
Paula Van Ness	CT Comm Foundation	203-753-1315

2 more

Sign in to speak during Public Comment period(s)

Name	Organization	Contact info: Address, phone, and email
William Pizzuto Ph.D.	UConn/WTBY Hospital	william.pizzuto@uconn.edu
Michelle Diaz	Waterbury Hosp.	mdiaz@wtbyhosp.org
Aaaie Geary	Waterbury Hosp.	Ageary1009@yahoo.com
Patricia Kinzly	Waterbury Hospital	pkinzly@wtbyhosp.org
Brenda Keller	Waterbury Hospital	bkeller@wtbyhosp.org
James Bayles	AAACH	
Graene Dorel	Waterbury Hospital	
Nicole Monnette	Citizen	
Paula Van Ness	CT Comm. Foundation	
✓ Steve Shrag	Community United	
✓ Tony Cusano, MD	Physician Waterbury	
✓ Cindinda Bylykbashi	WT Hosp.	

new

Sign in to speak during Question and Answer session

Name	Organization	Contact info: Address, phone, and email
✓ Brenda Monsalette	Communities United	
✓ John Thomason (John)	Naugatuck Valley Project	
✓ Blair Bartaccini	AFSCME Chapter 4	Retirees
✓ Michelle Valentino	Physical Therapy	

Exhibit 5

WATERBURY HOSPITAL

April 27, 2016

Samuel S. Lee
Chief Executive Officer
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd
Suite 400
Los Angeles, CA 90025

Re: Quality Assurance Commitment

Dear Mr. Lee:

Reference is made to that certain draft Asset Purchase Agreement, attached hereto as Exhibit A (the "Asset Purchase Agreement"), proposed to be executed by and among Greater Waterbury Health Network, Inc. (the "Seller"), by and on behalf of its Wholly Owned Subsidiaries, and Prospect Medical Holdings, Inc. ("PMH") and/or an affiliate of PMH (collectively, the "Buyer"), pursuant to which Seller expects to sell substantially all of its assets and those of its Wholly Owned Subsidiaries, as well as Seller's interests in the Joint Ventures (as defined in the Asset Purchase Agreement) to Buyer (the "Transaction"). Each of Buyer and Seller is referred to herein as a "Party" and collectively as the "Parties." Capitalized terms used but not otherwise defined in this Quality Assurance Letter (the "Quality Assurance Letter") shall have the meanings given to such terms in the Asset Purchase Agreement.

For good and valuable consideration, including the agreement by each Party to undertake the expense and effort of obtaining regulatory approvals needed to carry out the Transaction, the Parties hereto hereby agree as follows:

1. Buyer agrees that after the closing of the Transaction, Buyer will, for a period of two years following the Closing:

    a. maintain Seller's Performance Improvement and Risk Management programs in effect as of the date hereof, and be open to add additional staff to allow for focused quality and risk initiatives; provided however that such programs comply with Buyer's insurance, legal and claims management requirements.

    b. To continue in the Joint Commission Accreditation program;

    c. To maintain Seller's current reporting structure for the Performance Improvement and Risk Management Department, including direct report to the CEO Notwithstanding the foregoing, (i) Risk Management will also report up through Buyer's Legal department to ensure confidential communications and work product and (ii) settlement authority will be given by Buyer's Legal department.

    d. To implement and continue a structure to share evidence-based practices among PMH hospitals;

64 Robbins Street • Waterbury, CT 06708 • (203) 573-6000
www.waterburyhospital.org

Acknowledged and agreed.

BUYER:

PROSPECT MEDICAL HOLDINGS, INC.,
ON BEHALF OF ITSELF AND/OR ITS AFFILIATES

By: Deborah M. Berry
Name: Deborah M. Berry
Title: Prospect Medical Chief Quality Officer

Olejarz, Barbara

From: Lazarus, Steven
Sent: Wednesday, May 04, 2016 7:03 AM
To: Yolen, Susan; Hawes, Gary W.
Cc: Olejarz, Barbara; Greer, Leslie
Subject: RE: Testimony of Planned Parenthood in re: Waterbury Hospital Purchase

Thank you, Ms. Yolen.

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Yolen, Susan [mailto:Susan.Yolen@ppsne.org]
Sent: Tuesday, May 03, 2016 3:06 PM
To: Lazarus, Steven; Hawes, Gary W.
Subject: Testimony of Planned Parenthood in re: Waterbury Hospital Purchase

Dear Messrs. Lazarus and Hawes,

Attached please find testimony from Planned Parenthood of Southern New England pursuant to the hearing taking place today on the Waterbury-Prospect Medical Holdings purchase. I regret we were unable to testify in person, but ask that you include our comments in the record.

Regards,
Susan Yolen

Planned Parenthood®
Care. No matter what.
Planned Parenthood of Southern New England

Susan Lloyd Yolen

Vice President, Public Policy & Advocacy
Planned Parenthood of Southern New England
Planned Parenthood Votes! CT and Rhode Island
345 Whitney Avenue, New Haven CT 06511
p: 203.752.2807
susan.yolen@ppsne.org www.ppsne.org
NOTE: This transmission, and any files that may accompany it, contain information belonging to Planned Parenthood of Southern New England and are considered confidential and/or legally privileged. If you are not the intended recipient, any disclosure, copying, distribution or the taking of any action in reliance on the contents of this transmission is strictly prohibited. If you believe you have received this transmission in error, please contact the sender immediately.

Planned Parenthood of Southern New England
345 Whitney Avenue, New Haven CT 06511

MEMO

TO: Mr. Steven Lazarus, Office of Health Care Access
Mr. Gary Hawes, Office of the Attorney General

RE: **Waterbury Hospital Purchase by Prospect Medical Holdings**

May 3, 2016

Please accept the following written comments from Planned Parenthood of Southern New England regarding the impending Waterbury Hospital purchase by Prospect Medical Holdings. I regret that a representative of PPSNE was not able to attend the hearing this afternoon in Waterbury, but wanted our comments to be included for the record.

Comments of Susan L. Yolen, Vice President, Public Policy and Advocacy,
Planned Parenthood of Southern New England
Office of Health Care Access Hearing on Waterbury Hospital Purchase by Prospect Medical Holdings
May 3, 2016

Thank you for the opportunity to comment on the pending hospital purchase in Waterbury.

Planned Parenthood has had a long term interest in the preservation of comprehensive, hospital-based reproductive health care services for women. In addition, PPSNE operates a family planning center in Waterbury and has had a decades-long commitment to offering accessible, affordable basic reproductive health care in the community. Our staff is keenly aware of the range of needs of women of reproductive age in Waterbury.

Along with our allies in the reproductive health advocacy and provider community, PPSNE has weighed in on many previous hospital mergers in Connecticut, particularly when partners to the merger have adhered to religiously-defined limits on the range of services that women might receive, and when such limits would be applied to a newly merged entity that previously offered more comprehensive women's health care.

Representatives of our coalition met recently with Waterbury Hospital CEO Darlene Stromstad, and have been reassured that the pending purchase by Prospect Medical Holdings does not threaten reproductive health care at her facility. There are two concerns that our groups hold about the future, however, which we would like to place into the record of these proceedings.

First, we have seen a pattern in recent hospital mergers, wherein the corporate or nonprofit entity taking on a struggling community hospital begins to seek immediate cost savings after the consolidation. Diminishing or closing services such as a labor and delivery unit has been seen as a pathway to reducing costs. This very example is an open issue at community hospitals in both Connecticut and Rhode Island

right now. So it would be our request that approval of this purchase be contingent on the preservation of all existing women's health services.

Second, a key reason for the concern expressed above is that the only other hospital serving Waterbury and its immediate environs is St. Mary's Hospital. St. Mary's (itself newly acquired by St. Francis/Trinity Health) operates under the Catholic Directives for healthcare provision. The Catholic directives (ERDs) expressly prohibit the full range of commonly accessed reproductive health care for pregnant women. These prohibitions could include miscarriage management and contraceptive care, obviously include abortion, and could also include other common and medically standard procedures as post-delivery sterilization (tubal ligation).

For women in the Waterbury area, particularly those low income women covered by Medicaid, local access to these services, in addition to labor and delivery, is imperative. Were anything to jeopardize the purchase being discussed today, the women of Waterbury might not have access to any of the basic services prohibited under Catholic teaching. If Prospect were to diminish or end women's health care, assuming it can easily be taken up by St. Mary's, that care will be suboptimal, due to the religious restrictions. Additionally, we cannot assume that travel to a hospital facility in another city (Danbury, New Haven, Meriden or Hartford) will be possible for laboring pregnant women impacted by the diminution of services, whether for budgetary or religiously-defined reasons.

Our coalition understands that in the current environment, consolidation of hospital services across our state may indeed be both necessary and wise under some circumstances. Thus, we are following with interest the impending proceedings of the recently convened Governor's task force on hospital certificates of need. However, as a group, we maintain that comprehensive health care for women should not be "on the table" for elimination in a community like Waterbury, where local access to full and affordable health care is imperative.

Thank you for the opportunity to share this perspective.

Olejarz, Barbara

From: Lazarus, Steven
Sent: Wednesday, May 04, 2016 7:02 AM
To: Greer, Leslie; Olejarz, Barbara
Subject: FW: CCAG Testimony
Attachments: CCAG Testimony- Prospect CON.docx

Please add this testimony to the record.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Ann Pratt [mailto:ann.prattccag@gmail.com]
Sent: Tuesday, May 03, 2016 2:22 PM
To: User, OHCA; Lazarus, Steven; Hawes, Gary W.
Subject: CCAG Testimony

TO: Office of Health Care Access
Office of the Attorney General

FROM: Ann Pratt, CCAG

Please find attached our testimony on the Prospect Medical Group Application.

Thank you for this opportunity.

--

Ann Pratt
Director of Organizing
Connecticut Citizen Action Group
30 Arbor Street
Hartford, CT 06106

ann.prattCCAG@gmail.com
860-209-1234
Putting People First

Testimony from Ann Pratt, Director of Organizing, Connecticut Citizen Action Group
Certificate of Need Hearing
Prospect Medical Group and Waterbury Health Care Network

To representatives of the Office of Health Care Access (OHCA) and the Office of the Attorney General, thank you for this opportunity to submit testimony in regards to the Certificate of Need application by PMG Medical Group and Waterbury Health Care Network.

My name is Ann Pratt, and I am the Director of Organizing for Connecticut Citizen Action Group, and I submit this testimony on behalf of our members within the Greater Waterbury Region.

First, we want to express our strong support of Community United's proposal and request for PMG Medical Group (PMG) to agree to and sign a Community Benefits Agreement. This proposal sets forth common sense provisions that provide important guarantees for residents of the Greater Waterbury community, and stipulate crucial accountability measures ensuring that this newly configured for profit hospital system is truly accountable to the community, and particularly to those on Medicaid, Medicare, underinsured and uninsured. It is exceedingly disturbing, and alarming that PMG refuses to sign this common sense proposal, stating explicitly that it does not feel a need to be accountable to the community.

In reviewing PMG's application to OHCA we want to respond to and address several areas of concern:

1) PMG will create an Independent Foundation that will take on the promotion of and responsibility for addressing community health care needs, among other community health and wellness needs. PMG does not state explicitly, but certainly implies that the foundation will eventually be responsible for the Community Health Needs Assessment.

   We strongly urge OCHA strengthen PMG's responsibility and role in conducting and implementing the CHNA permanently. Maintaining the link between the development and implementation of the CHNA insures a level of accountability and centrality of this essential consumer health needs tool.

2) PMG commits to continuing Waterbury Hospitals current charity care program for **only** the next 5 years.

   We strongly urge OCHA to require PMG to strengthen its commitment to providing this service over a much longer period of time.

3) PMG states that it will continue the current practice of providing services to all Medicaid and Medicare patients, along with the community health and wellness services provided by Waterbury Hospital. (Pg. 53, Section 24). However, the commitment is for only 5 years.

   We strongly urge OCHA to strengthen PMG's commitment to serving this population over a much longer period of time.

4) PMG states that its value to the community will be demonstrated by the property taxes it will provide to the City of Waterbury, with the caveat that they will be seeking tax abatement-unspecified in terms of the length of request abatement that they will be seeking.

   We reject PMG's claim that their payment of property taxes is an example of the value and benefit their presence offers to the Greater Waterbury Community. Given that their first entrance into the region will be to secure unknown amount property tax subsidies from the City of Waterbury, and there are absolutely no guarantees that once the initial subsidy has ended, they will not seek another, even larger amount for future operations.

We understand that a Hedge-fund type organization can be adverse to making commitments longer than five years so they may consider these proposals to be generous. However, the health care needs of a community exist over generations, and their health and well-being needs do not magically disappear when a time limit has been reached. We urge OCHA and the Attorney General's office to take this into account within their deliberations.

Finally, it is difficult to fully trust the assertions made by PMG, given our direct experiences of how large profitable hospital systems have behaved and operated in Connecticut over these several years. Five years ago, when Hartford Health Care System took over Windham Hospital, they committed to strengthening and building the financial stability and overall capacity to serve the Windham community. Tragically for the Windham community, Hartford Health Care did not live up to this commitment and instead has systemically reduced services and undermined the health of this necessary and valuable community institution.

While PMG continually states that there are currently "no anticipated changes to services" this does not mean that there might not be such service changes implemented in the near future. Without a Community Benefits Agreement, or restrictions placed upon them during this CON, the community is potentially at risk of reduction in services and/or elimination of needed health care programs. We urge OHCA and the Attorney General's office to make sure these disturbing trends in our health care system are not continued with this proposal by PMG.

Requiring PMG Hospital to enter into a signed Community Benefits agreement put forth by Community United would be one step in this process.

Respectfully submitted,

Ann Pratt

Director of Organizing
CT Citizen Action Group

UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

Testimony Concerning the Waterbury Hospital / Prospect Medical Holdings Proposed Deal
Lynne Ide, Director of Program & Policy
Universal Health Care Foundation of Connecticut
May 3, 2016

Good afternoon. I am Lynne Ide, Director of Program and Policy at Universal Health Care Foundation of Connecticut. This is not the first time you have heard from us regarding hospital conversions in this state. We testified in 2014, during the Tenet hearing, here in Waterbury, and a few weeks ago in Rockville, at the hearing on Prospect Medical Holdings' proposed deal to acquire Eastern Connecticut Health Network. Some of what I say will be familiar, but we believe that there are critical questions that need be asked during any hospital sale, and that even more questions must be asked in a for-profit conversion of a hospital.

Our ultimate concern is rooted in the impact this deal will have on patients, consumers, residents and the community. A local hospital is a cornerstone in a community, providing local care, employing local residents, and participating in the local economy.

The concerns we have may not be new, but they are worth repeating.

Out-of-state and for-profit

As we testified in Rockville, the fact that Prospect Medical Holdings is an out-of-state for-profit company raises a red flag. Despite assurances in PMH's presentations and in the ECHN public hearings, we would be naïve to take these at face value. If PMH is seeking, ultimately, to turn a profit from this struggling hospital, it stands to reason that they will have to change the way the hospital has been doing business. We are leery of a takeover by a company who, by its very nature as a for-profit corporation, is accountable to its investors, not the local community.

Connecticut only has one for-profit hospital, Sharon Hospital, and promises to the community made during that transaction has remained unfulfilled. Sharon Hospital officials have shared little of the information that has been asked of them from the community, and the Foundation for Community Health (FCH). FCH arose from that hospital conversion.

To be fair, we are also generally wary of any local hospital takeover, in light of the situation faced by Windham Hospital last year. The critical care unit was changed to a progressive care unit, despite community protest.

Cost and quality in the context of provider consolidation, for-profit health care

We are deeply concerned about the evidence that shows that provider consolidation leads to higher prices and, in turn, higher costs to consumers. This increase in price and cost is not matched by an increase in quality.

Dr. Leemore Dafny, of Northeastern University, has found that provider consolidation generally increases prices, and quality doesn't improve.[i] We ourselves put out a paper on provider consolidation in health care, and our literature review reinforced Dafny's work—prices often go up, with little change to quality.[ii]

And what kind of players are for-profit health care companies? In a June 2015 report in *Health Affairs*, researchers noted that of the fifty hospitals with the highest charge-to-cost ratio, according to Medicare data, forty-nine of those hospitals were for-profit.[iii] This isn't surprising, as for-profit companies are accountable to their own bottom line, not the health of patients.

We offer this evidence, again, to put this deal in context. While we cannot know the ultimate impact this deal with have on the cost and quality of Waterbury Hospital, the evidence is not promising.

Community at the center

Waterbury is not Manchester or Rockville. The most recent Community Health Needs Assessment (CHNA) conducted in Waterbury, in September 2013, points to Waterbury's specific needs.

According to the Greater Waterbury Health Improvement Partnership[iv]:

- Median household income is $41,499 vs. $69,243 for all CT
- The unemployment rate in the city is 12.9% vs. 8.55% for the state
- 20.6% of the city's population were below the poverty level in 2010
- 3 Priority health issues include
    - Access to care
    - Mental health/substance abuse (Waterbury has the highest rates of suicide in CT)
    - Obesity
    - Tobacco use

In many ways, Waterbury's increased needs only increases our concern about this deal. Access to essential services and affordability are the consumer's concern, particularly for the city's working poor and Medicaid populations.

Waterbury deserves to have access to essential services that are affordable, for all residents. Essential services are not those most profitable for a hospital and health system, but those services that are critically needed in a community, addressing major health concerns of residents. Hospitals and the expanding health systems they build are ultimately responsible for ensuring the health of a community.

Caution, and strict conditions, to protect the community

We have seen the presentations Prospect Medical Holdings has shown to communities in Manchester and Rockville. They assure that care will be of high quality, that they will be responsive to the community, and that this is a good deal for the people of Manchester, Rockville and now Waterbury.

We urge the Office of Health Care Access and the Office of the Attorney General to place conditions on this deal that ensure Waterbury Hospital, and the Greater Waterbury Health Network as a whole, remain a responsible and responsive community member.

We believe the following are conditions that should be put on this deal:

- Require Waterbury Hospital, under Prospect Medical Holdings, to conduct a Community Health Needs Assessment every three years, and to develop and implement a plan to address high priority needs
- Ensure that Waterbury Hospital has a local board that is not entirely controlled by the hospital and PMH, and that includes local residents who truly represent the community
- Include an independent monitor to ensure that Prospect Medical Holdings abides by any conditions and agreements that are a part of this transaction
- Ensure the protection of charitable assets in the conversion from non-profit to for-profit, and that charitable assets not be utilized to offset uncompensated care, but to provide services that address community needs

Waterbury deserves a deal that protects them. If this is the only way to save the hospital, so be it. But this deal cannot go forward without conditions that protect the residents of this area. The community must be a valued stakeholder in this transaction.

Since Prospect Medical Holdings is both an out-of-state and for-profit company, it is even more important that they build trust with the local community. We urge both parties to seriously consider signing the proposed community benefit agreement put forward by Community United.

---

[i] Dafny, L. (2009). Estimation and Identification of Merger Effects: An Application to Hospital Mergers. Chicago: Northwestern University.

[ii] Universal Health Care Foundation of Connecticut. (December 2014). Hospital consolidations and conversions: A review of the literature. Available at: http://universalhealthct.org/images/publications/Hospital_Consolidations_and_Conversions.pdf

[iii] Bai, G. & Anderson, G.F. (June 2015). Extreme markup: The fifty US hospitals with the highest charge-to-cost ratios. Health Affairs, Vol 34, No 6, pp 922-928.

[iv] Greater Waterbury Health Improvement Partnership Final Summary Report, p.3

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, May 05, 2016 1:31 PM
To: Greer, Leslie
Cc: Martone, Kim; Hansted, Kevin; Cotto, Carmen; Stephen Cowherd
Subject: FW: OCHA testimony may 3,2016
Attachments: ocha hearing testimony may 3,2016.docx

Please add to the GWHN/PMH hearing.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: steven schrag [mailto:stevenschrag@comcast.net]
Sent: Thursday, May 05, 2016 11:38 AM
To: Lazarus, Steven
Subject: OCHA testimony may 3,2016

A rose by any other name

My name is Steve Schrag and I live in Waterbury and am a member of Community United and the Naugatuck Valley Project. Waterbury clergy, led by Dr. Edmund Rowland, and by a newspaper editor, organi□ed □hospital Sundays□in order to raise money to help build a hospital in Waterbury. The clergy will began the campaign in 1882.The pennies and nickels collected will eventually help capitali□e a sorely needed facility. These pennies and nickels helped to secure a vote for state matching funds for the collections from the □hospital Sundays□. This was the beginning of Waterbury Hospital. Our community has a lot of e□uity in this hospital and should be directly part of the process of its future.

Defining hospital community benefits agreements

There are 5,700 hospitals in the United States; 2,900 non-profit, 870 for profit and the rest are owned by state and local government (2009). This proposal to convert Waterbury Hospital from a non-profit to a for profit model has raised community concerns.

Non-profit hospitals must legally meet the IRS community benefit standard with re□uirements that include:

- Accept charity care to the extent of its financial ability and admit of all types of patients including those able to pay for care either themselves or through third party payers
- Maintain a community board
- Full time emergency room open to all regardless of ability to pay by limiting amounts charged for emergency or other medically necessary care to individuals eligible for assistance
- Prohibitions against the payment of excess compensation and impermissible private benefit
- Community benefits be reported at cost rather than charges and reported by employer identification number rather than by hospital or system
- Conduct a community health needs assessment and adopt an implementation strategy at least once every three years beginning in March 2012

Waterbury values regarding community benefits

We believe that community benefit means the provision of health care services that promotes preventative care and overall health and wellness and that improves the health status of the affected community which includes working families and populations at risk within the affected community. This includes uncompensated care; the total amount of charity care (not just bad debts) determined by using the hospital s published charges as the bases for estimates.

What we want

Community United has been working for a community benefits agreement since 2012 when the first for profit corporation wanted to buy Waterbury Hospital. The most recent draft version of a community benefits agreement includes what the Prospect Medical Holdings and Waterbury Hospital has said is already part of their legal documents. We have added to the proposal that they agree to talk with the community to find ways to even do better on community issues raised in the last 4 years.

The draft agreement states that the hospital will:

-no change in service lines or locations such as behavioral mental health, cardiology, cancer services, diagnostic and imaging services, emergency department, family birthing and neonatal care, gastroenterology, infectious disease clinic, intensive critical care, outpatient medical therapies, primary care, pulmonary, rehabilitation, surgical and telemetry

-**maintain current policies on charity care for a minimum of 5 years** with the possibility of extending it based on future discussions with the community

-while Waterbury Hospital is owned by a Prospect affiliate it will provide charity care-under applicable law unless otherwise negotiated with the community

-**accept Medicaid and Medicare for a minimum of 5 years** with possibility of extending that based on future discussions with the community

- maintain staffing according to state law

- continue to have cultural and linguistic appropriate services available to patients

-hire employees under usual and customary hiring process and will work with the appropriate unions to ensure continuity and stability in the workforce

-There will be a local board created with additional advisory committees to solicit community ideas and input

- seek input for capital projects from the local board and advisory committee to help identify community needs

- seek input for capital projects from the local board and advisory committee to help identify community needs

There shall be ongoing dialogue and discussion with Community United and others to identify language and appropriate methods of accountability regarding the following concerns:

- **Payment of property taxes** for the full amount of the Hospital s value
- Conducting a Community health assessment as often and with the same effort that is re uired of non-profit hospitals
- **Negotiation of a successor clause** that will ensure that all sections of this agreement will last in perpetuity
- **Complete facility based transparency** regarding finances, staffing and services provided by using the Waterbury Health Department website
- maintain support for parent engagement programs
- full-time clergy to meet the needs of patients and share appropriate staffing data with the community

This agreement is by no means comprehensive or as complete as we would like it to be. However we drafted it in order to make clear our willingness to compromise. The uestion is whether the hospital will compromise and sign an agreement with the community. We have met twice with Prospect Medical and they have stated several times that they think that it is not necessary to be accountable directly to the community. That raises uestions in our minds about their intentions.

OCHA s mission is to ensure that the citi ens of Connecticut have access to a uality health care delivery system. We believe that ensuring a direct connection to the community will help make that a reality.

We look forward to OCHA s help us to get a signature from Prospect Medical so that we can work together to make Waterbury Hospital a center of healthcare excellence for another 100 years. Or if that does not occur, please make our recommendations part of the Certificate of Need.

Thank you for your time and consideration.

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

May 6, 2016

VIA ELECTRONIC MAIL ONLY

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Darlene Stromstad, FACHE
President/Chief Executive Officer
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06708

Re: Revised Scheduling Agreement for OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02

Dear Mr. Spees and Ms. Stromstad:

This letter revises the schedule set forth in Connecticut General Statutes § 19a-486b(a) in connection with the hospital conversion dockets OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02 currently pending in the Department of Public Health, Office of Health Care Access ("OHCA") and the Office of the Attorney General (the "OAG"). The Applicants are Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH").

Due to the press of business at OHCA and the increased responsibilities of its review, OHCA has requested an extension of the 120-day review period as set forth below. The OAG agrees that the 120-day review period should be extended for this docket.

Therefore, pursuant to Conn. Gen. Stat. § 19a-486b(a) and after discussion, the parties have agreed to the following schedule for completion of the Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC hospital conversion review. Specifically, the parties agree to extend the 120-day review period set forth in § 19a-486b(a) until **July 15, 2016**. If it becomes apparent that we cannot complete the Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC review by the date established above, all parties will convene at the earliest opportunity to agree upon a revised final decision completion date.

If you agree to these scheduling terms, please sign the attached page (the signature page may be signed in counterparts) and return it to our offices at:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG
Email: gary.hawes@ct.gov

Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Kevin Hansted, Staff Attorney
Email: kevin.hansted@ct.gov

Very truly yours,

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General

Very truly yours,

Janet M. Brancifort, MPH, RRT
Deputy Commissioner
Department of Health
Office of Health Care Access

cc: Gary W. Hawes (via electronic mail)
Steven Lazarus (via electronic mail)
Ann Zucker (via electronic mail)
Michele Volpe (via electronic mail)

Scheduling Letter Agreement for

OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02

Signature Page

Darlene Stromstad, FACHE
President/Chief Executive Officer
for Greater Waterbury Health Network, Inc.

5/9/16
Date

Jonathan Spees
Senior VP, Mergers and Acquisitions
For Prospect Medical Holdings. Inc.

Date

Scheduling Letter Agreement for

OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02

Signature Page

Darlene Stromstad, FACHE
President/Chief Executive Officer
for Greater Waterbury Health Network, Inc.

Date

Jonathan Spees
Senior VP, Mergers and Acquisitions
For Prospect Medical Holdings. Inc.

5/10/16
Date

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

GREATER WATERBURY HEALTH NETWORK, INC.
AND PROSPECT MEDICAL HOLDINGS, LLC

GREATER WATERBURY HEALTH NETWORK, INC.
PROPOSED ASSET PURCHASE BY
PROSPECT MEDICAL HOLDINGS, INC.

DOCKET NOS. 15-32017-486 AND 15-486-02

MAY 3, 2016

1:03 P.M.

63 GRAND STREET
WATERBURY, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC, Greater Waterbury Health Network, Inc. proposed asset purchase by Prospect Medical Holdings, Inc., held at 63 Grand Street, Waterbury, Connecticut, on May 3, 2016 at 1:03 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. This public hearing before the Office of the Attorney General and Office of Health Care Access, identified by Docket Nos. 15-32017-486 and 15-486-02, is being held on May 3, 2016 to consider Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC application for the Greater Waterbury Health Network, Inc. proposed asset purchase by Prospect Medical Holdings, Inc.

The hearing is part of the procedure under what is commonly referred to as the Conversion Statute, which requires the Commissioner of the Department of Public Health and the Attorney General to evaluate any

proposal, which would convert a non-profit Connecticut hospital to a for-profit entity.

For OHCA's purposes, this public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a and 19a-486e, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I have been designated as the Hearing Officer for the Office of Health Care Access for this evening's hearing.

The staff members assigned to this case with me are Kimberly Martone, Director of Operations, Steven Lazarus and Carmen Cotto. The hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will make its determination on this application pursuant to Sections 19a-486d and 19a-639 of the Connecticut General Statutes.

Specifically, OHCA will consider the following; whether the effected community will be assured of continued access to affordable health care, whether the purchaser has made a commitment to provide health care to the uninsured and underinsured, whether safeguards are in place to avoid a conflict of interest in patient referrals, and OHCA will take into

consideration and make written findings concerning each of the statutory Certificate of Need guidelines and principles.

Generally speaking, there was a public need, access, quality and financial feasibility of the project.

Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, LLC have been designated as parties in this proceeding.

At this time, I'll hand it over to Deputy Attorney General Perry Zinn Rowthorn for some additional comments.

MR. PERRY ZINN ROWTHORN: Thank you, Kevin. As Kevin mentioned, I'm Perry Zinn Rowthorn. I'm the Deputy Attorney General for the State of Connecticut. I've been designated by Attorney General George Jepsen as the Hearing Officer for this proceeding.

I want to thank all of you for being here, the Applicants, the witnesses, the members of the public and public officials, whom we'll hear from today.

I want to take a minute or two to talk about what this proceeding is, put it in the context of our review of the pending application.

Before I do that, I do want to say a

special thank you to the members of the public, who are here today. We know that the Greater Waterbury Health Network and Waterbury Hospital are important assets in your community, and many of you have strong personal bonds with the hospital, so we take that seriously, hence our presence here today.

I know there's a lot of, also, a lot of employees. I see white coats and hospital scrubs here today, so we are anxious, as well, to hear from you, so your input is valuable to us.

We are, as Attorney Hansted mentioned, conducting this hearing jointly with OHCA, but we do have a different and distinct role in reviewing the transaction, a different focus and different criteria.

Our role here is defined and limited by the Hospital Conversion Act, Connecticut General Statute 19a-486.

That Act reflects the Attorney General's traditional role in protecting the public interest and charitable assets and insuring that monies and properties committed to a charitable purpose are safeguarded and used appropriately.

Non-profit hospitals and hospital systems, like Greater Waterbury Health Network, hold their assets

for essentially a charitable purpose, providing health care, not for generating profits for shareholders or owners, and, in that way, not-for-profit hospital systems are different than for-profit hospital systems.

The administrators of not-for-profit hospital systems are the stewards of its charitable assets with a responsibility to take good care of those assets.

The law does not prohibit non-profit hospitals from converting to for-profit status, but when one seeks to do so, as here, the Attorney General is charged with ensuring that the non-profit hospital is meeting its obligations of care for the charitable assets, and we look at three things, in particular.

We look at the process. We ensure that the process leading to the sale was responsible. We ask were the hospital administrators careful in deciding to sell and choosing a buyer and negotiating a transaction?

We look at the terms of the sale to make sure they are fair. Will the hospital get the fair market value? Will it get fair market value for its assets? And then we look at the proceeds of the deal after the sale. Will the charitable assets continue to be used for health-related purposes?

We need to ensure that those assets are protected from being used for the for-profit making purposes of the new hospital system.

Because the Attorney General must remain focused throughout his review on the charitable assets, his review and our decision for the most part do not focus on the running of the for-profit hospital after the transaction.

Issues relating to the operation of the new hospital entity, as it relates to access to health care services, are within OHCA's purview.

Today's hearing is a very important part, but just one part of a review that has been ongoing for months. We'll take testimony and evidence, and we'll hear public input.

We'll ask some questions, but don't assume, if we don't ask questions on a topic, that the topic is unimportant to us. We have received and reviewed thousands of pages of documents already, and we've asked many follow-up questions, and all of those materials are available on the Attorney General's website, www.ct.gov/ag.

Your input is important to this review. All the information we receive today will become part of

the official record of our review.

We'll do our best to accommodate everyone, who wants to speak. We'll also be taking comments in writing, and those comments will also be included in the official record.

We have sheets I think that many of you saw on your way in on the tables for those members of the public, who want to sign up to be heard, so, if you are interested, please do sign up.

Let me say a word about what the end of this process looks like. Under the statute, the Attorney General must approve the transaction as it is, deny it, or approve it with conditions that relate to the purposes of the Conversion Act.

For the Attorney General, that would generally mean that any conditions would relate to the Attorney General's focus on the hospital's charitable assets and the future protection of those assets.

This is a joint hearing, as we've mentioned. Kevin and I are going to work together to move this along to cover as much business as we can. You can assume that, if either of us makes a ruling on an objection or a procedural point, that the ruling is for both offices, unless we state otherwise.

I think there are sheets with the agenda for today, but let me just go through what you can expect this afternoon.

First, we'll hear Applicant's Direct testimony, so we'll hear, in essence, an overview of the transaction from the Applicants. We will then break, and then hear from members of the public, who have signed up or will sign up, then we will ask questions.

OHCA will ask questions first, and then, to the extent there are areas that remain uncovered, the Attorney General's Office will ask questions, then we'll hear closing remarks, and then we will adjourn.

So let me turn it back over to Kevin for some additional housekeeping before we get into opening statements.

Before I do that, I want to introduce the staff from the Attorney General's Office, who is working on this transaction.

To my immediate left is Henry Salton, Assistant Attorney General, who heads our Health and Education Department, and next to him is Gary Hawes, Assistant Attorney General in our Special Litigation and Charities Unit. We also have with us Cheryl Turner, who is a paralegal specialist, who has been helping with the

transaction. Cheryl is over here.

So, with that, thank you very much. Kevin?

HEARING OFFICER HANSTED: Thank you, Perry. At this time, I'll ask staff to read into the record those documents already appearing in the Table of the Record in this matter. All documents have been identified in the Table of the Record for reference purposes. Mr. Lazarus?

MR. STEVEN LAZARUS: Good afternoon. Steven Lazarus. For today's record, I would like to include Exhibits A through S, as listed on the Table of the Record, as well as we will be adding a new exhibit, Exhibit T. That is the copy of the Quality Assurance Commitment submitted by the Applicants this morning between Prospect Medical Holdings and Greater Waterbury Health Network.

We do have extra copies, in case some of you would like to review them.

HEARING OFFICER HANSTED: Thank you, Mr. Lazarus. Counsel, are there any objections?

MS. MICHELE VOLPE: No objections. Michele Volpe, legal counsel. I do want to note that, for the Table of Record, N, as in Nancy, it may be more

appropriately placed in the Table of Record of the ECHN hearing. I think that may have been a support letter.

MR. LAZARUS: I believe that was rectified this morning.

MS. VOLPE: Okay.

MR. LAZARUS: So the updated or the revised Table of Record does not include that one.

MS. VOLPE: Okay.

MR. LAZARUS: That was an error on OHCA's part.

MS. VOLPE: And, so, the quality letter is in the Table of Record as S?

MR. LAZARUS: Exhibit T.

MS. VOLPE: Okay.

MR. LAZARUS: N was --

HEARING OFFICER HANSTED: N is now the request for legal notification?

MR. LAZARUS: Yeah, because we did get additional exhibits, which were the letters of support, last night, so I think that took the place of the N.

MS. VOLPE: That took the place of N?

MR. LAZARUS: Yeah.

MS. VOLPE: Okay. So the letters of support were the 119 pages?

MR. LAZARUS: Yes.

MS. VOLPE: Okay. Great. Thank you.

HEARING OFFICER HANSTED: Attorney Volpe, do you have an updated Table of the Record? If not, we can provide you with one, and, if there are any other concerns, we can address it later in the hearing, if that's okay.

MS. VOLPE: No, I think they've been addressed. Thank you.

HEARING OFFICER HANSTED: Okay. As Perry started to mention earlier, for today's hearing, we will first hear from the Applicant for an overview of the project, then we will hear public comments on the proposal.

Out of deference to elected officials, we will call them first, and then we will turn to the sign-up sheet, which is provided outside the door on the table. And, again, any individuals, who wish to provide public comment, please sign up on the public sign-up sheet, just so we know who to call at the appropriate time.

Before we begin, would all the individuals, who are going to testify here this evening, please stand, raise your right hand, and be sworn in by

the court reporter?

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Thank you, all. And would each of you, who have just taken the oath, please identify yourselves for the record? You might have to move up to one of the microphones, so it's picked up.

DR. CARL SHERTER: Dr. Carl Sherter.

HEARING OFFICER HANSTED: Thank you.

MS. SUSAN CORDEAU: Susan Cordeau, Director of Performance Improvement.

MS. DARLENE STROMSTAD: Darlene Stromstad.

MR. CARL CONTADINI: Carl Contadini.

DR. MITCHELL LEW: Mitchell Lew, President, Prospect Medical Holdings, and I'd like to adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. STEVE ALEMAN: Steve Aleman, Chief Financial Officer, Prospect Medical Holdings, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. VON CROCKETT: Von Crockett, Senior Vice President for Corporate Development for Prospect

Medical Holdings, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MS. DEBBIE BERRY: Debbie Berry. I'm the Chief Quality Officer for Prospect Medical.

MR. JON SPEES: I'm Jon Spees. I'm the Senior Vice President with Prospect Medical Holdings, and I adopt my pre-filed testimony.

MR. TOM REARDON: And I'm Tom Reardon, President of Prospect East.

HEARING OFFICER HANSTED: Thank you. And we have some other folks, who are sitting in the audience. If you would just come up one at a time, please?

MR. JIM MOYLAN: I'm Jim Moylan. I was the previous CFO of Waterbury Hospital up until last Friday, and I'm a consultant to Waterbury Hospital, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MS. SANDY IADAROLA: Sandy Iadarola. I'm the Chief Nursing Officer from Waterbury Hospital.

HEARING OFFICER HANSTED: Thank you.

DR. JOEY COSGRIFF: Dr. Joey Cosgriff. I'm the Medical Director of Performance Improvement.

MR. RICHARD KROPP: I'm Richard Kropp,

Vice President of Human Resources.

HEARING OFFICER HANSTED: All right, thank you, everyone. And just a reminder, if you are testifying here today, before you initially testify, please just identify yourselves for the record, and if you have not already done so, please adopt your pre-filed testimony for the record.

At this time, we'll allow the Applicants to proceed with their presentation.

MR. CONTADINI: Thank you.

HEARING OFFICER HANSTED: You're welcome.

MR. CONTADINI: Carl Contadini, Chairman of the Board, Waterbury Health Network, and I would like to adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. CONTADINI: Today, we're going to overview the process that got us to where we are today. I will then turn this over to Darlene Stromstad, who will give her viewpoints on today and future plans.

Sue Cordeau will give a presentation on performance improvement and Waterbury Hospital Medical staff involvement, Dr. Carl Sherter will talk in regards to the Transaction Committee, and representatives from Prospect will have their own program today.

HEARING OFFICER HANSTED: Can everyone in the back of the room hear okay? Okay. All right.

MR. CONTADINI: It's been a long journey. Greater Waterbury Health Network began reviewing options for sustaining the organization more than 10 years ago.

In 2005, commissioned a study on the merger with St. Mary's Hospital. Those discussions went on in 2006 and 2007 between Greater Waterbury Health Network and St. Mary's Hospital.

In 2007, there was a draft OHCA report recommending consolidation of those two hospitals, and, in 2008, we were unable to reach agreement, and discussions ended at that time.

In 2009, Greater Waterbury Health Network defaulted on its CHFA bond covenants, and, in 2010, the Board engaged consultants to analyze projected capital needs. Anticipated cash would be depleted by 2015.

In 2011, the Board formed a task force to chart future course of Greater Waterbury Health Network, and we also, at that point in time, hired our new CEO.

In 2011, it was approximately February, we hired an investment banker, Cain Brothers, selected to lead the process to cast a net for the potential partners.

The priority at that time, which still is today, is sustainability, high quality, accessible health care.

In 2011, two finalists were selected, Vanguard Health and LHP. In August of that year, LHP, which had an LOI with St. Mary's, was selected, based on its promise to build a new hospital, were continued on the merger of the two hospitals through 2011 and 2012, and, by August of 2012, LHP terminated relationships with both hospitals and left Connecticut.

At that same time, in August of '12, Greater Waterbury Health Network's Task Force regrouped, met with St. Mary's Hospital to explore possibilities to work together, and no further path was identified.

In the fall 2012, the task force, again, dove back into the marketplace, reaffirms the priority to provide sustainable health, high-quality accessible healthcare, with a commitment to invest in outpatient service strategy, physician recruitment and capital upgrades.

In the fall of 2012, two finalists interviewed, Vanguard Health and Prospect Medical Holdings. In October of '12, Vanguard Health was selected.

August 2013, Vanguard announced a strategic alliance with Yale-New Haven Health Systems. October 2013, Tenet Health Care Purchases Vanguard. Tenet announced the inclusion of St. Mary's Hospital in the deal with two separate hospitals and Waterbury under one parent company.

In October of 2014, Greater Waterbury Health Network's public hearing. November of 2014, transaction approved, with over 70 conditions.

In December 2014, Tenet announced departure from Connecticut, and, in January 2015, in spite of political overtures, Tenet departed was final.

Greater Waterbury Health Network defines a two-part strategy at that point in time; try to rebuild our organization by simultaneously identifying potential partners.

In the spring of 2012, we identified a pool of potential partners and it was limited. I think we had two people of interest.

The LOI with Prospect Medical Holdings was announced. Greater Waterbury Health Network holds the first public hearing in August of 2015, and Greater Waterbury Health Network entered into a forbearance agreement with its bondholders in December 2012, '15.

Overview of the transaction. Forty-five-million-dollar purchase price, subject to certain adjustments; cash, assumption of certain liabilities, such as pension plans.

Fifty-five-million-dollar capital commitment, subject to certain adjustments; facility improvements, equipment updates and development of coordinated care regional care model.

Included in the transaction substantially all of the assets, including the hospitals, physician practices, joint ventures and real estate.

Excluded were restricted funds, charitable assets, the child care center, the captive insurance, inactive entities and other certain liabilities.

Continuing operations in Waterbury Hospital, the continuing involvement of an Advisory Board that included community representatives, capital investments to improve facilities and equipment, physician recruitment and network, hire all of the employees and assume contracts, continuation of charity care and indigent care, establishment of community foundation to oversee certain charitable funds, and that's the transaction in general.

The community foundation, a new, totally

independent foundation will be formed, hold or receive the benefits of certain charitable assets, receive the net proceeds of the sale, and no post-closing liabilities. Thank you.

MS. STROMSTAD: Good afternoon. I'm Darlene Stromstad. I used to be the new CEO of Waterbury Hospital. Now I'm the old CEO, and I adopt my pre-filed testimony.

It's good to see you again, and I thank you for your continued interest and attention to our organization.

I'm going to pick this up where we last left off, the winter of 2015. Mr. Contadini did a very thorough job of talking about the journey that brings us here today, so I want to talk about just the past year, since Tenet announced it was leaving Connecticut.

When that happened, our organization suffered deeply. After two years of effort, when the deal was called off last winter, our organization went into a depression. Employees left. Some doctors changed allegiances. Others invested in competitive surgery centers, and our confidence was shaken.

2015 was the most difficult financial year ever for Waterbury Hospital, and we've had a few, and it

was also the most difficult for my career. We had to balance the challenge of running a hospital known for quality, which was suffering financially, while working on a deal to bring us long-term stability.

We have definitely learned a lot during our past transaction attempts and understood clearly that this time the key to our success was finding a partner with a strong likelihood of bringing a deal to close, as well as meeting all of our other priorities, and Prospect was that.

They understood the regulatory environment of the Northeast. They recognized the immediacy of our needs, but would invest for the long haul. There would be little to no disruption to our services or to our employees, and they would bring us a new model of payment and delivery, and they had success in neighboring Rhode Island.

I don't need to repeat what I said at previous hearings before or what you have heard from other hospitals over the last couple of years.

Our industry is changing dramatically, and our reimbursement has only gotten worse. There's enormous financial pressure being placed on hospitals like mine, those that are single, standalone, with a very

challenging payer mix, and we are not immune to the requirement to adapt new payment and delivery systems.

As both a hospital company and a population health management company, Prospect brings the experience to position us to make the complicated move to a value-based delivery system, and their access to capital allows us to make the investment necessary to be a high-quality hospital for the long haul.

Waterbury Hospital. Maybe you think about us as the hospital on the hill, but we really are so much more than that. We have a very significant footprint in the Greater Waterbury area. These network affiliates combined that make up the Greater Waterbury Health Network.

Our issue is not one about volume. As you can see from our slides, each year, our employees have the opportunity to touch the lives of hundreds of thousands of people. Just this list alone on this slide totals more than 500,000. That's 500,000 patient encounters. That's half a million a year.

So as these numbers show, I am enormously proud that, in spite of our well-publicized financial challenges over the past few years, we continue to be the hospital of choice for much of our community.

Our past fiscal year, which ended September 30, 2015, is a year best looked through one's rearview mirror. The losses we suffered were devastating to the hospital and very personally and professionally humiliating and humbling, so I think it is very important for you all to know that today we are financially and operationally stable.

That means we are at break even, which is an enormous feat. It doesn't mean that we have capital to invest in the future, but because of the hard work of many of the employees, of doctors that work throughout our network, many of them are here today, it's to their credit.

Last fall, our employees and employed physicians accepted salary and benefit cuts to help us gain solid footing once again.

We asked for and received sacrifices from our employees, our medical staff and our Union, and I am pleased to say that all of those cuts have today been restored, and our employees and our physicians have never lost touch with our promise to our patients, that we would keep them at the center of everything we do, in spite of any distractions.

Their sacrifices, as well as many, many

other initiatives, have allowed us to dig ourselves out of a black hole, or a red hole, as it was, and I'm really proud of that, but it is simply not enough.

We do not have access to capital to be competitive and to remain sustainable for the long term. We have a proud history; 126 years of providing world class, high-quality health care in a teaching environment.

We care for some of the most at-risk people in the state of Connecticut, and we are enormously proud to do so, and this transaction will ensure that we are able to continue that.

Prospect's model will allow us to build stronger medical staff partnerships through our IPA. Already, we have more than 300 members. With the long history of population health management, they can teach us to become a leader in new delivery models that will be beneficial to the region we serve, and we'll be able to invest in equipment and outpatient services that will allow us to be more competitive and grow by attracting back the many patients, who have been lured away by larger, wealthier health care systems.

As you know, we've been at this for some time. Prospect helped us achieve the initial goals we

set for our transaction several years ago; sustainability, accessibility and the ability to continue to deliver high-quality health care.

Waterbury Hospital has received many awards over the years for its high-quality health care. That is who we are, and that is who we want to remain. Therefore, when we learned of CMS violations at two of Prospect's California hospitals, we undertook additional due diligence and formed a special board quality committee that undertook a rigorous review.

We needed to ensure high-quality health care would be delivered by all Prospect hospitals, including ours, in the future.

So to talk to you further about this process is Susan Cordeau, our Director of Performance Improvement.

MS. CORDEAU: Thank you very much, Darlene. As Darlene stated, I'm Susan Cordeau. I'm the Director of Performance Improvement at Waterbury Hospital, and I was one of seven members that were part of this task force, and we had representation that included our Board, medical staff, nursing and the Quality Performance Improvement Departments.

The task force was empowered or

established to review the immediate jeopardy CMS survey violations of the California-based hospitals owned by Prospect and, also, to review the corrective action plans to ensure that they went back into compliance on those violations. Dependent on the outcome of our review, we would make recommendations to our Board of Directors.

So the scope of our review, it was very broad, very deep. We requested from Prospect and they provided us the last three years of their CMS deficiencies for all of hospitals.

Each member of the task force received several binders of the violations of the documents that included the violations and their corrective action plans.

To ensure all members of this task force had a true understanding of the CMS regulatory process, I did provide the definitions of the CMS violations, which are standard, conditional, and then immediate jeopardy.

Obviously, we looked at everything very seriously, and then the areas of concern where we decided to focus were on the California hospitals, where there were three immediate jeopardy violations identified.

So, from there, we had long discussions, we reviewed, and we came up with a plan, and it was a

four-part plan. First, we developed questions that we wanted to ask to Prospect Health Care. We requested a conference call with a Prospect Medical Holdings executive.

We asked for an on-site visit at CharterCARE in Rhode Island with their Quality and Risk Department, so we could get a sense for how they were doing, and then, fourth, some of our senior leadership actually went out to LA and toured Culver City, which was one of the hospitals that had an immediate jeopardy violation.

So our initial concerns. The task force, we were all very confident in the high-quality health care we provide at Waterbury Hospital. We're proactive in our approach at Waterbury. We use evidence-based practices. Our policies and procedures support the CMS conditions of participation and the Joint Commission standards.

We audit our compliance on these to make sure that we are maintaining compliance, and we report that throughout the hospital at the management level, the staff level, and at a performance improvement, so we're very transparent, so we knew we had a good plan in place.

So our concern became will that change?

Will the quality of the Greater Waterbury Health Network be maintained?

Also, would there be adequate financial and human resources to ensure, for the Quality and Risk Departments, to ensure our future, that we could maintain this? Last, how does Prospect handle significant challenges?

So the specific issues identified in California hospitals, we came up with four concerns, four basic concerns; the pattern of the widespread ineffective sterilization processes, the issues of the temperature and humidity in the OR in some of the procedural rooms, the lack of leadership and governing body oversight, and a failure of the hospital to follow through on several of its corrective action plans.

So there is a typo in one of these, our results. So through our review, we identified there were three immediate jeopardy violations affected at two of the -- only two of the 14 Prospect hospitals.

During our conference call with Mr. Crockett, it became very clear that Prospect had a true understanding of the violations. They took things very seriously. They made a very big commitment, both financially and, also, to develop a very experienced

quality team.

Senior leader, Mr. Crockett, was extremely transparent and very knowledgeable. He could answer every question about every violation, and it was very reassuring to all of us on the task force as we sat in that room.

He provided detailed explanations and plans for change. He shared with us the new corporate organizational structure, which included a Chief Quality Officer, and I'm happy to report that Dr. Cosgriff, who is the Medical Director of the Performance Improvement Department, and myself had the pleasure to meet Debbie yesterday, and we share common goals and visions, as far as quality.

They also hired a Chief Clinical Officer, Chief Nursing Officer, an Associated VP of Regulatory Affairs and Patient Safety, and east and west coast Regional Quality Officers.

We heard and we're very reassured by Mr. Crockett that quality needs to be controlled and will be controlled at the local level, with corporate oversight and support.

That same great experience was just shared when we went to Rhode Island. It was very reassuring.

Their relationship with Prospect is enhanced. There are already robust quality and safety programs, and they shared with us that resources, both financially and with human resources, are consistently made available.

The processes are not difficult to get financial resources, and they already have a lot of corporate kind of -- what's the term I'm looking for? It's tough to be old, you know? You lose your train of thought. To their facility. They had already started to do major renovations to their facilities.

So, obviously, we came back as a task force, and we felt that the changes at Prospect we're able to make in a very short period of time reflected a commitment to quality and the availability of deep financial resources.

And, so, on April 13th, the task force met with the Board, our Board of Directors, and we went through the entire process that we did, and we made a proposal that the transaction with Prospect Medical Holdings move forward with recommendations, and that was unanimously approved by our Board of Directors.

And the recommendations have been memorialized in a quality assurance letter, and they maintain our current quality programs, continue Joint

Commission accreditation, maintain our current reporting structure to a local CEO, with a dotted line relationship to the Chief Quality Officer, share evidence-based practices across the systems, and then provide adequate financial resources to keep our facility always in compliance and staff for the Quality and Risk Departments.

I'd like to introduce to you Dr. Carl Sherter.

DR. SHERTER: I'm old, also, but that's okay. I adopt my pre-filed testimony.

My name is Carl Sherter. I'm the recent Chief of Staff of Waterbury Hospital. I'm a member of the hospital's Board of Trustees and on its Finance Committee.

I'm an original member of the task force that examined the hospital's opportunities with various capital partners.

I'm a practicing pulmonary and critical care physician. I'm in private practice, attending physician at both Waterbury and St. Mary's Hospitals.

I'm Chairman, proud Chairman of the State of Connecticut's Medicaid Pharmacy and Therapeutics Committee.

I've served as a volunteer since the inception of this committee. I helped write its bylaws. I've Chaired every meeting for over 13 years.

We have saved the State of Connecticut tens of millions of dollars and provided the most liberal list of medications for Medicaid patients. I understand delivery of affordable health care to the underinsured. These are our most vulnerable patients.

Over the last four years, we've looked for capital partners. We've heard health care has changed, and we've changed our goals.

Under the Affordable Care Act, health care systems will attempt to keep patients healthy and prevent hospitalizations. This will require a robust system of care, data driven, with ancillary services that provide the best care available to every patient.

Every health care system is starting to build this model. Our chosen partner, Prospect Health, has a system in place as proof of success with the system in multiple states. It will be up and running in months, not years.

Part of my due diligence was to visit a two-hospital system in Rhode Island that Prospect acquired about a year ago. We met with their Board

President, their CEO, their Chief Nursing Officer and six physicians, who proctor the system. One physician was in private practice, the others voluntarily employed.

We got to spend nearly two hours with this group and asked numerous questions. They said the best way to sum up the experience was that Prospect was real and delivered all that they promised, and physicians were very happy.

They were practicing accountable care medicine within months and it's working. The patients are happy and get much better care than the old way of practicing medicine. In Rhode Island, Prospect is eagerly taking on a Medicaid population.

Hundreds of physicians have signed up over the first year. They like the new model Prospect has offered.

This venture will be good for the proud city of Waterbury. Our population is older than most other Connecticut cities. The poverty rate is over 20 percent. Our unemployment is over 12 percent.

This venture will help stabilize our city and help our city move into the next phase of its existence. Possibly, a city of health care and higher education. I haven't passed that by the Mayor yet, so

you should know that.

Waterbury has provided excellent health care to the community. I'm proud of the over 1,000 physicians we've trained, many still in our area.

We have medical students from all three Connecticut medical schools. I'm proud of the nurses, certified aides, respiratory therapists, physicians' assistants and pharmacists that we've trained.

I'm proud of the staff of the hospital earning numerous awards, quality health care, in spite of the hospital's financial constraints.

As I've stated, for the last four years, I've represented the medical staff at Waterbury Hospital and the patients that this hospital serves in its attempt to find a capital partner.

I was at every meeting. Prospect has met numerous times with the physicians who practice in Waterbury. They have a full-time physician liaison, John Holiver, who is there, who is always available, has reached out to every physician group.

He comes to the staff executive committee meeting monthly to report on progress and answers questions. This makes the process completely transparent.

The physicians have asked every question and gotten honest answers. They support this venture. Over 300 Waterbury physicians have already signed up for Prospect's Accountable Care organization. This demonstrates their support.

After almost 40 years of practice in Waterbury Hospital, I've seen its recent problems as a standalone hospital. With an average physician age of over 59 years, it's getting increasingly difficult to bring young health care workers to Waterbury.

They want a secure future in their practice. They want modern equipment to diagnose and treat their patients. They want a stable future with a capital partner, who will help with this economy of scale.

They know the health care delivery model has changed. They want to hit the field running with this proven system. Prospect offers this.

The people of Waterbury want excellent health care in their own city. They are a community of family values, who support one another.

Most of my patients come to the office with family members. They ask me is it going to happen? I answer we certainly all hope so.

We need a capital partner to make this happen, and Prospect is an excellent choice. Thank you.

DR. LEW: Mitchell Lew, President of Prospect Medical Holdings.

Greater Waterbury Health Network and Prospect, committed to this community. Who is Prospect? We are a health care services company, and we operate local community hospitals, and what is standard within our company is that we utilize local governance and local physician leadership.

We make investments in our hospitals and our communities. For example, recently in Rhode Island, we've made significant investments into the facility. We're beautifying the entrance, we're expanding the emergency room, and we've built out the GI lab, and, in two communities in Southern California, we have opened two new hospitals, one in Orange County and one in Bellflower.

The stability that we provide is continued employment and creation of new jobs, and we also expand programs and services to improve access and quality.

We opened an emergency room in our hospital in San Antonio, Texas, and we have opened several urgent cares in Providence, Rhode Island and,

similarly, in California. We have opened several urgent care and wellness clinics.

A little bit about the hospitals that we operate. Fourteen community hospitals, seven in California, four in Texas for about four years, two in Rhode Island, and it's been almost two years, and one recently we opened in New Jersey.

We serve many different communities. Many of the hospitals that we have are in underserved communities. To us, we take all types of health insurance, because, to Prospect, a patient is a patient.

All of our hospitals across our system provide various services. As you can see, medical, surgical, psychiatric, so we've got a lot of experience in multiple areas, but we also have many outpatient clinics and centers, because, in our model, not all care is delivered in a hospital.

And while we are a hospital company, we also are a medical group company. We operate and manage many physician groups, and you can think of our physician entity as a multi-specialty health care provider without walls, and, so, we link our physicians in what we call Independent Practice Associations, or IPAs, where physicians focus on delivering the best care.

In this model, physicians can be employed or they can be independent. We are an open model, and, so, whatever a physician desires, to be employed or remain independent, we can accommodate them.

We're a very large group in Southern California. We've been operating for over 20 years. And, also, growing in Texas, where we have nearly 500 doctors. Rhode Island, it's 300 doctors, and New Jersey about 125 physicians.

We contract with all health plans. We have nearly 9,000 physicians under contract, taking care of over 300,000 patients, and we coordinate care across the entire continuum, and what that means is, if a patient is in a hospital, or in a skilled nursing facility, or at home, we follow the patient throughout their care.

Our goal is to achieve the best clinical outcomes and the best patient experience, because we want our patients to go and tell their family and friends to come get their care with Greater Waterbury and Prospect.

Now through our experience of owning and operating hospitals and medical groups, we've come up with what we feel is a very unique model of care, which we call Coordinated Regional Care, or CRC, and what

Coordinated Regional Care does is it integrates the hospitals and the physicians and other medical and community providers, so, in this community, there might be a durable medical equipment company, or a palliative care company, or a skilled nursing facility.

We work with the local providers, and we also will work with the local health plans to coordinate the care, because we need to do that to improve care and get that patient satisfaction, and this model we have already implemented in several different regions in California, Texas and Rhode Island, and, as I alluded to earlier, currently underway in New Jersey and already here in Connecticut.

Population health management, you hear this term frequently, and basically to us what that means is that the care of every member in this community matters.

Our unique model of care will provide higher value, and what that means is that great care does not need to cost more.

Improving care and outcomes, so how exactly do we do this? What is the secret to providing for better care? And, so, we take a patient-centered, but a physician-led approach. We have multi-specialty

care teams that identify the highest risk patients, and those are usually the sickest five percent, and these teams are comprised of nurse practitioners, pharmacists, social workers and health educators that work together, and they will actually be available 24/7 to these patients, so if a patient needs to call, they call us, and, if necessary, we will go to their home to evaluate whether or not they need to be hospitalized. That's the type of care that we provide. We engage the patient and the family. We have this homebound program that I just spoke of.

Disease-specific care plan, so specific for diseases, such as diabetes, or congestive heart failure. We have certain protocols that we follow to make sure that a patient has the best standard of care that is evidence-based.

We also are integrating behavioral health. As we know, behavioral health is a very common problem in all communities, and it's important, when you're taking care of one's physical health, also to integrate taking care of their behavioral health needs.

We have quality care coordinators that reach out to patients every day to call them and remind them that they need to come in to their physician for

their testing, whether it be a mammogram, or to check their cholesterol. We have teams of coordinators that do this.

And then following patients, as I mentioned earlier, whether it's a hospital, a skilled nursing facility, or some other institution, we case manage and we follow across the entire continuum, and it's a physician-led network.

MR. ALEMAN: Hi. I'm Steve Aleman, Chief Financial Officer, Prospect Medical Holdings, and I wanted to take just a few moments to walk through the demonstrated kind of financial history of Prospect Medical Holdings and the demonstrated financial performance.

What's here on the slide, I reference both the growth and revenue. This is the compound annual growth rate and revenue and adjusted EBITDA since 2011. 2011 is important from a date, because this is the year before we started acquiring facilities outside of California.

If I included the growth rate prior to that, when the company really came together, the medical group and hospital segment back in 2007, the growth rates would even be higher, but this would give kind of a fair

review over the last four years.

On the revenue compound annual growth rate, that was really driven between organic growth, and that's growth in our existing facilities prior to acquisition, as well as strategic growth, and those are acquisitions, and that strategic growth was really focused to date in these numbers on the Rhode Island transaction, CharterCARE Health Partners, as well as the Nix Health System in San Antonio, Texas.

Conversely, though, the adjusted EBITDA growth rate of 25.6 percent is really almost solely driven by organic growth rate, and that organic growth rate is driven by continued process improvements in our facilities, continued cost deficiencies, movement towards managed care and related supplemental payments that have driven both the top line revenue growth, as well as adjusted EBITDA.

Focusing on acquisitions and integration, I've touched upon CharterCARE Health Partners. I'd also like to highlight a recent transaction of ours in New Jersey, East Orange General Hospital, because they both have similar traits that, when we stepped in and signed the APA for those particular transactions, they both had a negative run rate, of which we invested into those

facilities, just like we're investing from a manpower standpoint in Greater Waterbury Hospital to help begin to turn performance around and work directly with management.

And, indeed, we were able to turn the monthly run rate financial performance of both those facilities around from where they were running at about a negative $1.2 million a month to break even or positive.

The East Orange General Hospital facility, we entered into that transaction in 2014. It was a fairly lengthy regulatory review process, but we just closed that in March, and the first month of financial performance under us they actually were accretive month one and actually had a positive EBITDA month one for the month of March, and that really gets to this last point, that we work with the given facilities to help improve performance, operational and financial, and anticipate the acquisitions will be accretive year one, due to that improved performance.

How do we do it, and how do we deal? I specifically deal with the rating agencies. The focus has been our diversified model, and our diversified model is fairly unique, in that we reduce our concentration or our risk not only away from a given business segment,

such as whether it be a hospital segment or medical group segment, but as well as various states, payers and streams of revenue.

The medical group side, and this diversification also helps give us steady and predictable cash flow to help ultimately reinvest into our facilities, that diversification comes on the medical group side, with the steady capitation payments and management fees, on the hospital side, with the diversified payer mix between commercial, Medicare, Medicaid, as well as managed care and supplemental payments that are driven from those programs, and it gives us the ability to satisfy our acquisition commitments, without taking on additional debt.

Specifically, going back to the acquisitions I've highlighted, the Nix in San Antonio and CharterCARE in Rhode Island, we acquired those solely off cash generated from operations and the capital commitments that we have carried forward, those formal commitments in Rhode Island, and the significant dollars we've invested into the Nix have all been from cash flow generated from operations, without taking on additional debt.

Which gets to what is our access to

capital, and I've highlighted what we have the ability to do is not only leverage the strength of our financial performance, the cash generation to reinvest that into our facilities, but we also have taken a very conservative approach to taking on debt, solely for the reason that, if from a strategic purpose there becomes a need or desire for us to go out and tap capital markets, that we have the ability to do that.

Our industry leverage ratio comparison gives our current industry comparison to other key, other public for-profit companies, and our goal is generally to keep our leverage ratio below four.

You can see we're well below that, which gives us the ability at any time to access the markets, both bank and bonds. In addition to that, we were a publicly-traded company and have maintained that reporting discipline, as well as financial discipline, which makes us attractive to private equity groups and the strength, the financial strength that they can provide.

We actually are with Leonard Green & Partners, who provide us that capital backstop, should we ever need it. Today, we have never needed to access them as a financial backstop or seek any additional

investments, and that's kind of the various access to capital and kind of the strength that our model provides.

MR. CROCKETT: Von Crockett, Senior Vice President for Corporate Development for Prospect.

As Mitchell Lew, Dr. Lew, indicated, our physician groups have an extensive program for managing the health of the members that they serve, and, in the process of measuring the health, one of the national groups, which is called CAPG, that measures the effectiveness of physician group performance, has awarded our physician groups in California the status of -- Elite status, which is in the top four to five percent of medical groups, as it relates to providing appropriate and efficient and effective care for our patients, and we're very proud of that.

Additionally, our medical groups have also been recognized and rewarded by the Medicare program, and we have received -- all of our medical groups have received either a four or a five star for Medicare, as well as being recognized by the Department of Managed Health Care and cardiovascular, as well as cholesterol and diabetes care.

On the hospital side, recently within Rhode Island, our Cancer Center has recently been

designated by the American College of Surgeons as an academic comprehensive Cancer Center, and it's one of only 15 percent within the entire nation.

Additionally, within Rhode Island, Blue Cross has recognized our facilities for their surgical care in hip, knee and spine, as well as the surgery programs.

In Texas, we've recently received a Center of Excellence from Joint Commission for Bariatrics, and, in California, our hospitals have received top 10 percent nationwide, as it relates to provision of care within surgery.

However, there have been a few recent events within California that have recently come to light that have caused us to enhance our quality and expand our oversight of quality to our various California, as well as the proposed acquisitions.

With me we've brought Debbie Berry, who has recently been hired as the Chief Quality Officer and has an extensive background in quality and working in a large health care organization that has had oversight over multiple facilities, and she'll be testifying here shortly, in terms of what our enhanced quality program is going to be.

To touch briefly upon the events that have occurred within California, I'll just spend a few minutes on that for the room.

We, in California, we have recently now seven hospitals, but, at the time, we had six hospitals, and they're consolidated under two licenses, and, so, within the six-hospital structure, we had two of the hospitals that recently received notification from CMS that we were in violations of their conditions, Medicare conditions of participation.

The first issue was within Los Angeles Community Hospital, which is a three-campus system in East Los Angeles, and the issue arose. The hospital did a self-report to CMS, as it related to an allegation of physician misconduct.

The hospital had taken appropriate actions at that time, and when the Department of Health came out to do a survey, they had found that the actions that the hospital had put into place had not been adhered to by the physician and were not strong enough.

As a result of that issue, what's called an immediate jeopardy violation, as it relates to not safeguarding patient rights, and that occurred in November of 2015. The immediate jeopardy violation was

abated during the time of the survey, however, as part of the survey process, the organization was found to be in violation of five Medicare conditions of participation, which include the physician rights, nursing services, and infection control, among part of those.

As part of receiving the immediate jeopardy violation, CMS also placed the hospital on a 90-day proposed termination track of the Medicare agreement, giving the organization an opportunity to submit a plan of correction to correct the deficiencies.

The organization submitted the plan of correction, and a resurvey of the hospital occurred in February of 2016.

During the resurvey process, the issue associated with the immediate jeopardy was found to be we were in compliance associated with that, however, there were two issues, where the facility remained out of compliance, and it was infection control and nursing services.

At that point, CMS extended the proposed termination track to June 21st and gave the organization an opportunity to submit a plan of correction.

The plan of correction was submitted in early April, and the organization just recently underwent

the second resurvey by the Department of Health on the week of April 25th. The resurvey resulted in all deficiencies being cleared, and, as such, we expect to receive shortly a report from CMS, clearing the organization of all deficiencies, as well as removing the termination track associated with -- before the June 21st deadline.

The second issue occurred at our campus, which is called Southern California Hospital. It's a three-campus system underneath one license, with the focus of the survey issues primarily at the one campus, which is Culver City.

A little backdrop, which is in early of January of 2015, the organization was in the process of doing construction work, and our contractor had a small localized fire on the roof that caused for the damage of the HVAC system, making it inoperable.

The organization put temporary measures in place in the summer of 2015, and those measures were inadequate. As a result of that, there were complaints that were issued to CMS regarding primarily temperature and humidity within the organization.

During the survey process, during the survey process, the organization was issued an immediate

jeopardy for being out of compliance for temperature and humidity in the organization, which was abated during the survey process.

During the survey process, at that point, we received notification that the organization was also out multiple areas of Medicare conditions of participation.

While the hospital was in the process of responding to that report, CMS conducted what's considered to be a full validation survey, and that survey occurred on December the 18th, the week of December the 18th, and the results from that survey is that Medicare found that the organization was out six conditions of participation, which included infection control, and issued the organization a second immediate jeopardy, specifically to the sterilization of surgical instruments in the operating room suite.

That second immediate jeopardy violation was abated during the survey process, and surgeries resumed at that time.

As part of the issue of being issued the immediate jeopardy violation, the license, which included the three hospitals under Southern California Hospital, was issued a proposed 90-day termination of the Medicare

provider agreement at that time.

The organization was given the opportunity to submit a plan of correction, and that plan of correction was submitted on March 22nd.

The resurvey by the CMS or Department of Health was conducted on the week of April the 4th, and we are still currently awaiting the results of that CMS survey.

One of the things that, as part of receiving these issues that I've outlined, a couple of points. The first one was that, under both of those scenarios, there was actually no allegation that actual patient harm occurred underneath any of the violations or the immediate jeopardy citations that were given.

However, the organization takes these concerns extremely serious, and we started working on them immediately upon being informed by the Department of Health, as well as CMS.

As part of our response to make sure that the organizations were going to be meeting the conditions of participation, we hired a national consulting group to come in and assist both organizations until they're actually cleared, and they currently are still working with us, as related to the Southern California Hospital.

With that, we have modified multiple of our operating policies, as well as enhanced our quality program and oversight.

MR. ZINN ROWTHORN: So this is probably a good juncture to remind folks that this is our third hearing with Prospect Medical Holdings. We had two hearings in connection with the ECHN transaction, and we had very substantial discussion about these immediate jeopardy issues.

We are taking, in this proceeding, notice of the record of that proceeding, so all of the material and testimony at that proceeding is part of this record and vice versa.

It's very helpful for those, who are here, however, to have an overview of this topic, in particular, and, in particular, to have updates, but I do want to remind folks that the extensive discussion already on this subject is part of this proceeding, as well.

Also, I see that there are some folks standing. There are some seats up here, if people would be more comfortable sitting down.

I'm reminded that the transcripts from the two days of testimony of the ECHN proceeding are already

available online and on our website, if folks are interested in looking at those. I apologize for that interruption. Please proceed.

MS. BERRY: Hi. My name is Debbie Berry. I'm the brand new Chief Quality Officer for Prospect Holdings, Medical Holdings, and I'm going to speak to you a little bit about our future and our plans to improve quality and patient safety across the company.

First of all, our philosophy is that the right care is provided to the right -- the right patient receives the right care at the right time in the right setting, and our mission is to improve our care outcomes, provide patient safety, integrity, communication and collaboration with all our colleagues.

Our goal is to become a high reliability organization, to promote patient focus, high quality, safe, compassionate, efficient and effective care.

Being new to the company, I had to start somewhere, so I adopted, we agreed to adopt the quality of care framework, which says you need to have that infrastructure in place, you build the processes to support that infrastructure, and then you measure, you have outcomes, and you measure those outcomes and continue on from there, so that's kind of where I'm

starting.

First of all, I was asked to put together a draft quality and patient safety structure for the company, remembering that I've only been here for two weeks. I used my experience from a very large health care system, 173 hospitals, and, also, a much smaller health care system that consists of seven hospitals.

I pulled some of the best practices from both of those, plus did as much research as I could in evidence-based journals, in quality improvement journals, and, also, took a very close look at what was happening across the company.

So, based on this, this is the structure that I have put together, and, again, it may change a little bit. I've only been here two weeks.

MR. ZINN ROWTHORN: Can I interrupt before you do that?

MS. BERRY: Yes.

MR. ZINN ROWTHORN: It perhaps would be helpful if you told us a little bit about your background.

MS. BERRY: Oh, sure. Absolutely.

MR. ZINN ROWTHORN: Thank you.

MS. BERRY: I'm sorry. I'm a nurse and

always a nurse. A nurse first and always. I have been a nurse for 31 years. I have been in clinical practice much of my career, either as a clinical nurse, as an educator, or as a clinical specialist, so I'm very in tune to the clinical world.

I have experience in performance improvement, both in hospitals and across the system, and, most recently, I spent the last seven years with the Hospital Corporation of America, HCA, where I was first an Assistant Vice President of Quality and Clinical Operations, and then a Vice President of Quality and Patient Safety for the HCA system in one of their divisions.

In one division, I had oversight of 17 hospitals, plus multiple surgery centers, freestanding EDs, etcetera, and, in the other system, in the Gulf Coast system of Houston, I had oversight for 14 hospitals, along with surgical centers and on site, free site EDs.

I have taught for many years part-time in nursing programs, Baccalaureate and regular, and, just to give you some of my credentials, I am published, I am subject matter expert on quality and patient safety for Lippincott, for Core Measure events.

I produce in their policy and procedure manual, and I'm also a subject matter expert for two universities on quality and patient safety. Anything else?

MR. ZINN ROWTHORN: Thank you.

MS. BERRY: Okay, good. Thank you. Let me talk a little bit about our proposal here. Again, we have a Chief Quality Officer.

The important thing is that we have decided that we are -- we have grown, so we're going to divide into an eastern regional and a western regional VP of Quality to help support and provide facilitation to the facilities on the east coast, Texas and on, or the east coast and then the west coast and Texas.

Beyond that, one thing that I found it very clear to me and, also, based on past experiences, we really needed to get in front of the survey activity and build our own internal consulting firm, I guess, around survey readiness, so we put together a proposal that we have a VP of Regulation and Accreditation programs, and, under that, we are going to build a system of experts that can come out before a survey happens, come out if a survey happens where we have an issue, and, also, help build tools and build expertise across the company around

those high-risk areas, such as infection prevention, environment of care, life safety clinical practice, so we're going to have our own preemptive program, so that we can really monitor how well we are towards survey readiness.

And, again, all surveys do, all accreditation does is make sure that we're doing the right thing for the patient, so it's going to be a very patient-focused program.

I'm going to switch to the next slide. Part of what I was asked to speak to is a model that I have. I do like to have a corporate Quality and Patient Safety Steering Committee that has input from the hospitals in the company, and, also, not just the hospitals, but certain -- it's a multidisciplinary team, so there will be physicians, nurses, that kind of thing, so it's kind of a Steering Committee.

I'm just going to show the structure there, and I'll talk a little bit later of some of the roles, but it will flow from corporate, and then there's some regional activity, and then the hospitals will actually roll up into those regional activities.

The main purpose of that is communication. We need to maintain communication across the entire

company, so we can learn from each other, so we can share best practices, as my colleague over there had mentioned, and mutually move forward into the 21st Century.

The other thing that I have a slide here is just to show -- am I stuck? Oh, there we go. I'm sorry. The other thing within the Steering Committee, we will also be building some subcommittees, the subcommittees around things, such as clinical excellence, and when I mentioned those, I mentioned things like sepsis and all those very high-alert, very serious illnesses, infectious disease preparedness, so that, if something happens around infectious disease, we are ready to get out the facilities and help.

Certainly, quality and patient safety, medication safety, hospital-acquired infections and hospital-acquired conditions. These committees may not all start. There will be probably a gradual progression, but really try to get the input and get a focused movement across the company.

Under these committees, we may have work teams, and, in work teams, I try to pull people closest to the work to help us design best practices, based on best evidence, and share across the company.

I heard a lot about high reliability

organizations, that both Rhode Island is very involved in and, also, East Connecticut. I am also -- I'm sorry. The Connecticut hospitals.

I am also a very big believer in high reliability. It's the only way that we can decrease medical error in a hospital system.

We are going to move forward into that high reliability program. We are adopting high reliability behaviors to ensure a reduction in overall medical errors.

We are working on leadership commitment, and lot of work has already been done at the CEO level and CNO level just in the short period of time we've been here.

We are going to be working on building a very strong culture of safety and widespread deployment of highly effective performance improvement tools. Many of those tools are high reliability tools, such as SBAR, which is a communication tool that we use in nursing and health care, in general.

Part of our strategies to make, our outcomes that we're looking for, we are going to support ongoing survey readiness, and I mentioned the team that we're going to have in place.

We are going adopt patient experience, clinical excellence and high-reliability best practices, create and adopt data dashboards and analysis tools, so that we can benchmark not only with our company, but, also, with those, who provide the best care in the nation, so we're going to benchmark against the top 10 percent of the country.

We're going to promote consistent risk identification and medication, so what we learn from some facilities on the east we can share with facilities on the west and vice versa.

We're going to optimize pay for performance and publicly reported outcomes. Any time that the state and federal government wants to pay me for doing the right thing, I am 100 percent behind that, so we are going to work through that.

And, also, something very important is integrate technology. Technology is growing so very quickly we want to move forward with it and make sure it's integrated in our quality and patient safety plan.

Also, I had mentioned the quality and patient safety councils that we're envisioning. The purpose of those quality and safety councils will be to analyze data and trends for performance improvement

opportunities, assist with development of our quality and patient safety agenda, which we hope to update every year, provide organizational knowledge and systems thinking, motivate and strategize for organizational change, and ensure compliance with action items, so that we don't have a repeat of what we had on the west coast.

As part of that team that we are putting together and as part of this council, there will be monitoring of action plans, and, also, provide oversight for charter committees and work groups.

MR. ZINN ROWTHORN: So let me -- were you just about to hand --

MS. BERRY: I was going to hand off.

MR. ZINN ROWTHORN: Let me, if you don't mind, ask you a couple of questions at this juncture.

MS. BERRY: Absolutely.

MR. ZINN ROWTHORN: And I recognize that you're new to the organization, but it sounds like you've had the chance to roll up your sleeves and propose a detailed plan with respect to quality improvement and maintenance.

Have you had the opportunity to understand in some detail the problems that arose in the California hospitals?

MS. BERRY: I have. I have reviewed all the action items, all the standard violations or conditional violations, whatever, and the action items for those.

I actually have read them all. I believe that they've done a thorough, incredible job with identifying those issues and going after them. I think they've really gone after them well from my experience.

MR. ZINN ROWTHORN: Okay and can you talk, if you could, about whether and how the steps and structural changes that you've outlined would have prevented those issues from occurring?

MS. BERRY: Sure. Well, number one, I think that the most important part to prevent is to have the survey readiness team available with a group of experts on those high-risk areas, so that we will actually go in and do pre-surveys before anybody comes in.

I plan on scheduling them at least yearly at this point, so that a group will come in of experts and do essentially a mock survey.

Not only will they say this is wrong, this is wrong, this is wrong, they're going to also share those tools, share the support, share the expertise, so

that they improve immediately, and then continue to monitor that action plan, and that's key.

You can't just go in and say what's wrong. Part of this team's function will be to monitor everything that we found, monitoring it to completion, and then making sure they continue to monitor it, whether it's a sample or whatever, to make sure that they are achieving compliance with the standards, so that is -- it's a model that has been used across many organizations, and I think it's going to work very well for us, and actually kind of even being a little proactive now. Some of our other facilities are trying to get some specialists in to continue to be survey readiness, so I think that will help.

MR. ZINN ROWTHORN: Have you had the opportunity to gain an understanding of Waterbury Hospital's quality performance?

MS. BERRY: I have. I'm certainly not an expert. I did spend all day yesterday at Waterbury. I had the great pleasure meeting with Joey and Susan. They have a very robust program.

We shared a few best practices across the table, but I am very impressed with their program. I intend to use them, some of their practices, as best

practices, because I have identified them as best practices, so that we can share across the company, and I think they also have some opportunities, and we're going to continue to work on those opportunities, as well. I think it will be a very good partnership.

MR. ZINN ROWTHORN: One of the things that we've struggled to do since becoming aware of the immediate jeopardy issues is to understand those issues in context.

Just the phrase, immediate jeopardy, has a severe ring to it, and understand that the hospital could be at risk of no longer being able to participate in the Medicare or Medicare program. Particularly, a number of hospitals grouped under two licenses is alarming.

It's something with respect to these systems that we're looking at here. In Connecticut, it's something that I don't believe there's much, if any, experience with, threats of immediate jeopardy terminations.

How many hospitals are part of the HCA system?

MS. BERRY: One hundred and seventy-three.

MR. ZINN ROWTHORN: One hundred and seventy-three. Do you have experience in those hospitals

with immediate jeopardy termination threats?

MS. BERRY: I'm not going to speak directly to HCA, but I can tell you that, in the past 10 years, I have experienced seven immediate jeopardies with conditions, conditional status, and had to work with the sites to get them out of that, so it's not -- I mean and especially certain areas of the country seem to be more attractive than others, and Florida is one of those areas that there's a lot of activity, a lot of state and CMS activity.

MR. ZINN ROWTHORN: What would explain regional differences in that?

MS. BERRY: How can I explain the regional?

MR. ZINN ROWTHORN: What would, for example? We've heard some reference to regional differences between, for example, California and here. Our understanding it's the same set of CMS regulations.

MS. BERRY: They are the same. I think it's more the activity of the state, how actively involved the state is in doing complaint surveys, or doing any kind of just random surveys.

In 2015, the state started doing surveys around infection control, discharge planning, and I think

that increased -- that started in Florida very quickly. To my knowledge, it hasn't started over here in LA yet, so I think that's part of it.

MR. ZINN ROWTHORN: Okay and Mr. Crockett referenced the Department of Public Health, which I assume is a reference to the California Department of Public Health?

MR. CROCKETT: Correct.

MR. ZINN ROWTHORN: And, so, CMS is a federal regulator, federal program, so, for the benefit of those here, the relationship between a State Department of Public Health and CMS with respect to survey or immediate jeopardies issues is what?

MS. BERRY: Go ahead. Do you want to speak to that?

MR. CROCKETT: So the Department of Health, when a complaint is made to CMS, the Department of Health acts as an agent upon CMS and goes in and conducts the survey on CMS's behalf and will report the survey findings to CMS, at which point, then, CMS will make a decision or a determination upon those findings, so the Department of Health is an agent of CMS.

MR. ZINN ROWTHORN: Thank you for that. Just to paint this in broad strokes, I think what we

would want to hear are some detailed explanations, I think you've touched on it, is to the extent we have an organization that has a good quality history, how can you assure us that that control of quality and maintenance of quality will be local, but within a national company will be supported by the national company?

MS. BERRY: Well, first of all, I'm a firm proponent if it's not broken, I'm not going to fix it. I'm not going to spend the energy to fix it, so I think, right now, they have a lot of things that are not broken, so we will focus on things that may be.

According to CMS and Joint Commission, the onus or responsibility for oversight of the quality patient safety program falls to that Board, the local Board.

We serve or we will serve as facilitators, as support sharing best practices. We are I like to say very much kind of a facilitation and, at some point, consulted, however, if there are issues that are, for lack of a better term, may place a patient in immediate jeopardy of harm, or if there are issues that are new regulatory, you know, CMS changes, conditions, participation frequently, the Joint Commission changes things, then we will reach out to them and say, you know,

we need to work on this, because it's a new regulation.

So, again, I don't see us forcing things down. Number one, it's just not my style, but very much partnering with them.

MR. ZINN ROWTHORN: Thank you. I think this is a topic we'll probably hear more about today when we get to questions. I wanted to sort of identify some of the broad themes here in advance of our public comment. Feel free to continue with your opening comments.

MR. SPEES: Good afternoon, everyone. I'm Jon Spees, and I lead the transactions practice for Prospect. I wanted to spend just a little bit of time talking about the terms of the transaction and the commitments that we, Prospect, have made to both Waterbury Hospital and Greater Waterbury Health Network and, also, to the community as part of the transaction commitments, which have been described in our asset purchase agreement.

As Darlene mentioned, we're talking about essentially a $100 million transaction, which is split $45 million, in terms of the purchase price at closing, as well as a capital commitment of $55 million.

The capital commitment is to be used for

investment in GWHN's facilities in growth of its services, in development of the coordinated regional care model, and other investments in expanding assets and developing the system, and really finding ways to retain health care services in Waterbury, which are currently being exported to other areas, and retain jobs and build the community network here.

I wanted to just mention, so, Darlene talked about what a difficult year 2015 was for Greater Waterbury Health Network, and as the result and fallout from those difficult times, their cash reserves have been significantly depleted over the past year, to the point where there's some concern about whether or not there would be enough cash, as of the closing of the transaction, to satisfy the bond holders and allow them to transfer the assets to that, to Prospect.

So we've continued to monitor the cash position and forecasts of cash at closing, in order to -- as Darlene also mentioned, you know, choosing a partner that was committed to close the transaction was key for them, and we've continued to work with them and actually have now agreed, based on the most recent estimate, to make a couple of changes in the transaction.

It doesn't reduce our overall commitment

to the transaction. It just changes the allocation between purchase price and assumed liabilities and capital commitment, so, in order to increase the opportunity to actually close the transaction and satisfy the bond closers, we made a couple of fairly significant changes to the purchase agreement, the first being to eliminate the holdback, and there were provisions previously of a four-and-a-half-million-dollar holdback at closing that was to be used to satisfy any post-closing liabilities, and we've agreed to waive that holdback, which then frees up an additional four and a half million dollars of cash at closing.

And we've also agreed to limit the deduction from the purchase price for the liabilities that are assumed as of the closing, so that it can be -- it will be limited in its amount, and we've agreed to assume liabilities in excess of that threshold amount up to an additional $5 million.

That also will free up if there are liabilities at closing that are greater or free up cash at closing, and the trade there is, if we actually do end up assuming additional liabilities as the result of that, is that the offset would be against the future capital commitment, so, in total, the commitment is the same.

It's just allocated slightly differently.

The last piece I'll mention on the capital commitment is that there's provision to restructure the capital commitment if there is a regulatory action that is discriminatory against for-profit hospitals, and the purchase agreement calls for that restructuring to occur in cooperation with the local Board.

We've had some conversation on this in the past, and, so, we're open to -- it's not our intention to ever eliminate the capital commitment dollars, and we're certainly also open to some limitations on the time period that we could defer any capital commitment expenditure in the unlikely event that that would occur.

MR. ZINN ROWTHORN: Thank you. And I should probably note, for the benefit of the folks, who weren't in our previous hearings, that we did have some discussion about that potential limitation on the capital commitment, and, in light of future regulatory or legislative acts, which would be perceived to be discriminatory at a for-profit hospital system, we've expressed some concerns about that, as you know, and, in particular, the concern that we are evaluating a deal, as structured now, its fairness and not with respect to potential unknowable future legislative action, so I'm

glad to hear that you are thinking, in terms of some flexibility in that regard, and are sensitive to the concerns that we've raised about it.

MR. SPEES: Just, also, in addition to kind of the financial terms of the transaction, I wanted to talk about other aspects of our commitment and community benefits that will result from our commitments that we're making in connection with our purchase agreement.

Prospect has committed to continue the current charity care policies of Greater Waterbury Health Network, and we've also made a significant commitment to maintain the clinical services. There's a very long list of what's been defined as essential services in the purchase agreement that Prospect has committed to maintain.

As part of the transaction, we'll retain local management, and we'll create a local Advisory Board. I'll talk a little bit more about the local Advisory Board in a minute.

And we've also made our commitment to hire all of the employees of GWHN, who are in good standing, and I'll answer the question what does good standing mean?

From Prospect's standpoint, we'll conduct a single screen on the employees as a pre-employment screen, and that relates to being -- not being on the exclusion list for participation in federal health care programs.

And we've also, in response to concerns about the quality issues in California, we've entered into a quality assurance letter, in which we commit to maintain and continue to work with the local Advisory Board with respect to Waterbury's quality programs, and we are very confident that that letter, which will govern in connection with the significant corporate resources and the program that Debbie spoke about, will give great comfort to people here in the community about maintaining and not just maintaining, but enhancing Waterbury's quality programs.

I'll talk a little bit about the Advisory Board. The Advisory Board is really a key part of Prospect's model. We very much believe that health care is delivered locally, and the Advisory Board is one of the key intersection points that we have with the community to consult with and to get information and feedback from community members, in terms of issues of importance to them, in terms of strategic plans for the

health network, input into our capital plans, and essentially being our partner in developing the health network into what it can become.

They're also involved in medical staff credentialing and will be delegated responsibility for the medical staff credentialing, and they'll oversee and manage the accreditation process in concert, in cooperation with our corporate, our oversight plans.

As we talked about, they will be principally responsible for administering this quality assurance letter.

It's very key to us to have a close relationship with our local Board, in terms of how we conduct business going forward.

Our initial thoughts about the local Board is that it will be 11 members. Five will be from the current GWHN Board, and that will be nominated by their Governance Committee.

Prospect also believes very strongly in having physician input at the Board level, and, so, we want to have five physicians on the initial Board, as well as commitments made in the purchase agreement that the hospital's CEO will be part of the Board and, also, the chief of the medical staff, and recognizing the

importance of the quality of the senior quality executive will also be on the local Board.

And it would be our plan to have staggered three-year terms for Board members, so that it would continue to evolve and reflect the current views of the community.

Selection criteria, obviously, we want our Board to represent the community, in terms of diversity, and to be qualified and possess backgrounds and experience that would be consistent with Board roles and responsibilities, and we want Board members, who are committed to GWHN's mission and to helping Prospect achieve that mission going forward.

MR. REARDON: Hi. I'm Tom Reardon, President of Prospect East. My first slide, you know, it's easy -- talk is cheap, and, so, we wanted to demonstrate what we do, rather than just what we say.

I should point out that Lester Schindel, the CEO of CharterCARE, is here today, and I think he'll comment in the public comment section, and with him is Kim Lumia, who many of you know, who had been the CEO at Sharon Hospital, working with Les at CharterCARE now, and will be working in New England with Prospect.

So, with respect to CharterCARE in Rhode

Island, the two hospitals in Rhode Island, both Roger Williams Medical Center and Our Lady of Fatima Hospital, frankly were in a lot of trouble when we came in.

I must say that we're not all the way there, but we've turned them to a positive EBITDA. We formed a multi-specialty IPA that actually Mitchell has about 500 physicians at this point. I think it's about 120, 121 primary care docs.

We have gone out and employed 50 physicians, not because that's our model. In fact, it is not. We actually prefer physicians to remain independent, but if they want to be employed, we'll do it, so we've hired 50-plus physicians to add to the network at CharterCARE.

We've expanded outpatient clinics beyond the service area. We've invested in not one, but two outpatient oncology centers. As earlier noted, we've achieved academic certification of the Cancer Center. We provided significant strategic capital.

Again, when we talk about capital, we're talking about the whole network. We're not just talking about facilities. We don't have an edifice complex.

Nevertheless, with respect to facilities, as someone mentioned earlier today, we're already into

doubling the size of the ER at Roger Williams Medical Center, expanding services at Our Lady of Fatima, expanding the GI clinic, and a whole host of other things, including you can't walk into either hospital right now, because the facades are being completely redone, and they're being made appropriate, in terms of Americans with Disabilities Act and the like, so there's significant capital being invested.

We are implementing the first Medicaid pilot project in the state, which we're very proud of. We came to the Governor and suggested it, and we are going to suggest the same here in Connecticut and have already started that process.

We have the first Blue Cross Blue Shield risk contract with delegated functions in the history of Rhode Island, and, so, Les will talk a little bit about the number of lives we have and what we're going to do to expand, but we're off to a significant start to really transform the way health care is delivered in Rhode Island. We're pretty proud of our accomplishments in the year and a half, almost two years we've been there.

In the quality program, which was mentioned earlier, I know at the ECHN hearing and I think, again, today, with respect to the quality program,

one of the things that ECHN folks asked is, okay, when Prospect came aboard, did you diminish the quality programs, and what they were told was to the contrary. Two additional positions were added, so, again, we're backing the quality programs at CharterCARE. Both the ECHN and the Waterbury people were very impressed, and there's a lot of cross-fertilization capabilities, a lot of cross-huddles that will go on, in terms of higher reliability.

In fact, the Connecticut hospitals are further along than CharterCARE is, but we're embracing the whole high reliability model.

So why Prospect? If you could move to the next slide? Oh, you've got it there already. We really do believe that we provide better community health.

Mitchell got into this a little bit, but we are not a hospital-centered company. We actually are focused on taking care of the whole patient and getting sure that that -- making sure that that patient gets the best care, at the best cost, at the best setting.

We will follow the patient into the home. We're knitting together both physical health and mental health, which is something nobody really has achieved, and it's something that needs to be done.

We are empowering local physicians. The reason we have 500 physicians now at CharterCARE is that I'd say 30 percent of them came from beyond our initial service area, had no relationship to CharterCARE, but because they are now empowered under risk contracts, they're the ones that determine where patients go and how people will be paid. They come to the system, because they love it. The patients love it.

In terms of maintaining or creating jobs, we're a growth company, and, when you get right down to it, Waterbury Hospital is the largest employer in the City of Waterbury. There's 1,800 good jobs here. We need to get this deal done, and we need to preserve those jobs and grow the system.

For too long, St. Mary's and Waterbury have been focused on each other. We need to look outward. We need to expand services.

In terms of providing resources, I've often said we bring three things to the table. We bring capital. There's no question about that. We bring data-driven management tools, and we bring population management capabilities, and we're already seeing some of that benefit at Waterbury, and we'll see a lot more of it as we go forward.

Maintaining local leadership, Jon said it correctly. We believe all health care has to be local. It can't be delivered from LA. It can't be delivered where I live up in the Boston area from there. It has to be local, so we support the local management team and the local Board.

I've already mentioned investing significant capital, not just in facilities, but service technologies across the network.

We preserve charity care policies. In fact, many of our hospitals are safety net hospitals. We embrace vulnerable populations. We see that as part of our mission, and we think we do a heck of a good job with risk contracts.

A lot of systems, both non-profit and for-profit, have fled the inner city. Not us. To the contrary. Our most recent acquisition in East Orange is urban, urban, urban, safety in that hospital, so we embrace that capability.

Partnership advantages. Again, as Mitchell has talked about, right now, what you have is a fragmented system, and there's an expression about more heads than beds. The more you do, the more you get paid.

What we're trying to do is put together an

entire network of delivery of care, and it may include surgery centers. It may include a whole host of things, community mental health systems, and, so, what we're trying to do is integrate the entire thing, led by physicians. That's not to say that Waterbury Hospital is not going to be part of it. It will be.

And, in some ways, it seems counter-intuitive, because we talk about trying to keep patients out of the hospital, but what we find, and I've made this comment before, the CEO of our company, Sam Lee, always says more and better for less.

If you can do a better job and you can do it for less money, we're going to have more volume, and that's what we've seen time and time again, and, so, that's what we do.

We really do believe it's better care and health of the patients, so the patients love it. If you can treat a patient at home and take care of all their needs, it really does provide better care.

We've mentioned an increased access to capital and financial strength, and we do think that this is a sustainable delivery model that will preserve Waterbury Hospital and physician practices and quality health care in this community.

I have to give Carl and Darlene unbelievable kudos. With scotch tape and band aids, they have continued to provide the highest quality of care, I mean big time, and that's recognized by national organizations. It's really very impressive. We want to maintain that.

So why Prospect? To the next one, Jon? We're committed to Connecticut. Why do we like Connecticut? As I kidded at the ECHN hearing, it's easy for me to drive down from Boston, but that's not why Prospect wants to be here.

We like New England, because there's a couple of things in New England that we think are perfect for our model.

First of all, there's very little managed care penetration, in terms of real risk contracting. It starts slowly, but you move the ball, and when we really get to risk contracting, that makes all the difference, because once you have 88 cents on the dollar and you can invest it for preventative care, right now, under fee-for-service, you have no money to do that, but, under this model, you can do preventative care, it really is significant, and, so, there's tremendous amount of opportunity in Connecticut, as well as New England.

MR. ZINN ROWTHORN: Mr. Reardon, I apologize for interrupting, but just for purposes of clarity and for the benefit of the public here, there's a theme that has developed in your comments about population management and risk contracts, as opposed to fee-for-service.

It would be helpful if you could give a very broad overview of what that decision is that you're making.

MR. REARDON: Well Dr. Lew can probably do that better than me, but let me start. In terms of population management, what everybody is talking about right now is getting away from fee-for-service.

Right now, the more you do, you more you get paid, and I gave an example at ECHN, and it's a silly example, but it illustrates the point.

You go to your primary care physician, and that primary care physician may be the most dedicated person in the world, and they'll order some tests, and then you go to a specialist, and that specialist may be the most dedicated person in the world and cost-efficent and all the rest, and he or she will order tests, and then you go to the hospital and you'll get tests, and then you'll go to the nursing home and you'll get tests,

and what we try to do is integrate all this.

In the old days, when we had capitated payments, it was about denial of care. What we're about is give us the 88 cents on the dollar, and we'll coordinate the care across the entire health care spectrum, and we'll take care of our patient population that are assigned to us, so that's what I'm talking about when I talk about population management.

Mitchell, do you want to add to that?

DR. LEW: Sure. So what Tom described is a more traditional fragmented type of care, and, with our model, it's much more coordinated, so, with these networks that I spoke of, the primary care and specialists are all part of a network that are talking to each other through IT and using the same data to access, so there's not a lot of duplication of services.

And, then, through some of these teams that I talked about, the teams that go to the patients' homes and the teams that call the patients, we make sure that there's a proper handoff from the primary care to the specialist or when a patient goes into the hospital to the hospital's team and the physicians that see the patient in the hospital, and then the patient will get handed over when the patient is transitioned, either to a

lower level of care or back home, and, so, there's a lot more coordination, there's integration of all of the providers, there's less duplication, and with our different payment structure, we do this under a budget, so that we're watching the dollars that are being spent, and, so, we can save money out of the health care system.

And, so, these are the types of models that we took, as Tom alluded to, in Rhode Island when we went to the Governor and we said, Governor, we have a model of care that can provide the outcomes and the quality with a savings on your budget, and that's why she was very excited about approving a Medicaid pilot project in the state of Rhode Island, and we would love to do something very similar here, is to develop our model with the physicians here in Waterbury, and then go to the state of Connecticut and talk about some of our successes that we've had in Rhode Island and how we can provide a better quality of care with savings.

MR. REARDON: Let me just add a couple of quick points, if I can.

DR. LEW: Go ahead. Sure.

MR. REARDON: Right now, if you look at what we call metrics, for every 1,000 Medicare patients, you can expect them to spend collectively X number of

days in the hospital. In Connecticut, my recollection is it's about 1,400 days in the hospital. With many of the Prospect hospitals, it's 700 and some days, so think of the cost savings just there, and yet they're getting better care at home. They're not risking infection or any of the rest of the things.

The state of Connecticut has adopted a State Innovation Model that is suggesting that patients being moved from fee-for-service to population management or to value-based payment, 80 percent of patients within just a couple of years, how are they going to do that, because nobody knows how to do it?

I don't mean to be derogatory in that regard. It takes time to learn how to do this. You don't learn it overnight. We've been doing it for 29 years, and, in fact, CMS, we've talked a lot about CMS, is they've tried to get hospitals and other systems ready for population management.

They've come out with something, called an Accountable Care Organization. The first ones were not a big deal. It was about shared savings, however, they've now come out with something called a Next Generation ACO, where they really will do downside, as well as upside risk, and only 21 organizations in the United States have

been qualified to do this. Prospect is one of these organizations. We believe we can be transformative in the way health care is delivered in Connecticut.

And, so, on the last slide, just to wrap up, we talk about higher quality, higher patient satisfaction, highest value. It really is the triple aim. I'm a true believer. I do believe this model can actually help us get there, and we're excited to be here partnering with Waterbury Hospital.

That concludes our direct testimony.

HEARING OFFICER HANSTED: Before we get to the public comment section, we're just going to take a five-minute break.

(Off the record)

HEARING OFFICER HANSTED: Please take a seat. We want to get going again. Okay, looks like everyone is almost back. We're back on the record.

Just one housekeeping matter. Attorney Connors, did you have any objection to the Table of Record?

MS. KRISTIN CONNORS: No. Kristin Connors and Ann Zucker from Carmody Torrance Sandak & Hennessey on behalf of Greater Waterbury Health Network, and we do not have any objection to new Exhibit S. I'd just like

to note that there's over 110 letters of support. It looks like it's one exhibit.

HEARING OFFICER HANSTED: Okay, thank you, Attorney Connors. And now we're ready to move to the public comment section of this afternoon's hearing.

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: Okay. At this point, OHCA has some questions. Ms. Cotto, if you want to begin? Kim? Go ahead.

MS. MARTONE: Hi. Kim Martone, OHCA staff. We're going to do this a little bit differently today, as opposed to going through and asking you questions, at least from my part.

What I'd like to do is kind of summarize, particularly for Prospect, things that we've discussed in prior hearings, things that we've, you know, had agreement on, things that have been thoroughly discussed, so we're not going to go through it again today.

What I'm going to ask Prospect to do is just confirm agreement, or if you have a question, we can discuss it again, but these are things that we discussed at the ECHN/Prospect hearing, and it's really for them, just to go over it. It's for the community and the public to know what's been discussed, and things that

have been agreed upon, and our assumption would be the same thing, would be agreed upon for the purchase of Waterbury Hospital, if approved.

Okay, so, the first item that we discussed was the community health needs assessment. We had discussions regarding if Prospect has done -- conducted in other states, if it was the same as the federal government requires for not-for-profit hospitals, and I would just like the Applicant to confirm that they will participate and they would conduct with the community.

We heard testimony today, or a couple of the comments from the community action agency from Easter Seals, other health organizations in the community, so would you confirm that you would work with these community stakeholders, with representatives from the medically-underserved populations in conducting the community health needs assessment or study for the Waterbury area?

MR. CROCKETT: Yes. We've discussed this in detail with Waterbury, and our understanding is they are currently participating in the Greater Waterbury Health Improvement Partnership, and Prospect has agreed, in conjunction with Waterbury, to go forward, and we'll do the commitment for a five-year period at the same

participation level that they're currently participating in.

MS. MARTONE: Can I ask why only for a five-year period?

MR. CROCKETT: It was simply matching it up with our other commitments within the asset purchase agreement.

MS. MARTONE: Okay, well, we also have questions about why there's a five-year commitment on others, but we'll just leave it at that at this point.

Something new, based on public comment that was given today and because we are the Department of Public Health, the importance of aligning these community health needs assessments with Healthy People 2020, as well as the Department's health improvement plan.

I would assume that you would confirm that, as well. When you're looking at a community health needs assessment, you would be looking at state and federal health plans, as well.

MS. VOLPE: Can you give them some additional information on what you just stated, because I don't believe that has been ever discussed.

MS. MARTONE: No. That's why I'm bringing it up now. So in terms of a community health needs

assessment, you know, the federal government doesn't really have standards or guidelines by which have to be followed, so, at the state level, we're looking at having these community health needs assessments really align with Healthy People 2020.

MS. VOLPE: Which is what? Healthy People 2020?

MS. MARTONE: Healthy People 2020, Healthy Connecticut, they're statewide and national plans that look at chronic disease and obesity and, you know, areas of significant concern for populations, so we would want to align with those goals, and we also have a Department State Health Improvement Plan, which aligns with Healthy People 2020, as well, which goes to the public comment, as well, that was given today.

MR. SPEES: Wouldn't that be something that would be decided by that larger group, of which we're only part?

MS. MARTONE: The larger group? I'm sorry?

MR. SPEES: The Greater Waterbury Health Improvement Group?

MS. MARTONE: Yes. Our hope would be that Prospect will be part of that participation, part of that

community needs assessment, but with you as the purchaser, we want to confirm that that will be done.

MR. CROCKETT: We'll confirm our participation in the process if that's accurate.

MS. MARTONE: Thank you. The second area that was discussed and public comment was given and the importance of having an independent monitor, so we had talked about Prospect retaining the independent monitor for a certain length of time, possibly three years.

That monitor would report to OHCA. They would really look at the compliance of any conditions that came from an approval of this proposal.

MR. REARDON: We are open to that, as we said at the previous hearing. What we want to make sure, I mean, we can be talking about hundreds of thousands of dollars of expenditures.

We wouldn't want to see an independent monitor for OHCA, an independent monitor for the licensure division, an independent monitor for the OAG, etcetera, etcetera.

MS. MARTONE: Understood.

MR. REARDON: Okay.

MS. MARTONE: The next area was a three-year service plan. There is a statute that does require

other proposals to provide a three-year service plan to OHCA, so we want to confirm that service plan, that you could confirm that a service plan would be submitted to OHCA, in terms of any consolidation, reduction, termination of service, expansion of services, going along with the timeline with the community health needs assessment.

MS. VOLPE: So, in terms of that, obviously, there's a fair amount of statutory and regulatory oversight when you want to terminate a service, add a service, so, of course, (coughing).

Are you suggesting something beyond what statutory (indiscernible - too far from microphone).

MS. MARTONE: Yes, a service plan, a three-year service plan to meet the Waterbury community's needs.

MS. VOLPE: So, as Mr. Crockett explained, so if we're working with the Greater Waterbury Health Network partnership and a community health needs assessment is done, is determined, based on that community and what's needed, are you suggesting that this would be something different and separate from that?

MS. MARTONE: Yes.

MS. VOLPE: Okay and I think we need to

have a better understanding of what's involved with that before we can respond to that.

MS. MARTONE: Well it's not really what's involved. It's just confirmation that there would not be an issue with submitting a service plan to OHCA, in terms of any, like I said, any change in services that is being contemplated.

HEARING OFFICER HANSTED: Right, so, without getting into specifics, is there any objection to, at some point, submitting a written three-year plan of how PMH and Waterbury Hospital will proceed with respect to the services offered to the community?

MS. STROMSTAD: I would just like to ask this question or state what to me is sort of obvious. We wouldn't want to make public strategic plans that put us on -- that kind of play our competitive hand.

HEARING OFFICER HANSTED: Right. We're not asking for anything confidential or strategic.

MS. VOLPE: So this is something that -- is it a reporting obligation you receive from other hospitals?

MS. MARTONE: Not at this time. We haven't received one yet. Let's put it that way.

MS. VOLPE: So this would be a new

requirement imposed on a hospital in Connecticut?

MS. MARTONE: On hospital acquisitions and conversions, correct.

MS. VOLPE: So is there a sample of it?

MS. MARTONE: No, we don't have a sample of it. It's really up to -- it's your plan. It's whatever is developed.

MS. VOLPE: Right, but, as Darlene said, to the extent that it does contain -- I mean, fortunately, it's a two-hospital town, you know, but we wouldn't want to be disadvantaged from, you know, our co-city hospital, to the extent that we're divulging a three-year plan to you that we feel is important to implement, so I think you need to appreciate that, and we need to absorb what you're saying, because it isn't something that's already, you know, active here in Connecticut.

HEARING OFFICER HANSTED: We'll leave this open for further discussion.

MS. VOLPE: Thank you.

MS. MARTONE: Also, discussion over the capital investment plan and a timeline for capital projects. Public comment was given today about renovating the emergency department, about new

technology, so, if not available at this time, we would be looking for you to submit some type of capital investment plan.

MR. SPEES: Yeah. We fully intend to honor the commitment that we're making with respect to the capital commitment, and we're happy to provide, you know, details of the capital investment plan, as it's developed.

The important part of that is that we'll have to be flexible, because, as has been discussed many times today, that things are changing pretty rapidly, and, so, I don't think it would be in anyone's interest to fully commit in a binding way the entirety of the capital commitment, because that would eliminate any opportunity to respond to change in circumstances, so we're happy to share with you sort of in general terms where we expect the capital to be deployed.

MS. STROMSTAD: I just wanted to say I think we did submit a list, a simple list of some life safety issues and other major global service priorities.

MS. MARTONE: Yes. We also discussed maintaining current policies, charity care policies for the indigent population, community volunteer, community benefit policies, so we're looking for confirmation that

that would be held, as well, for this proposal.

MR. CROCKETT: Could you repeat the question, please?

MS. MARTONE: Maintaining current policies, such as charity care policies that are offered by Waterbury for the indigent population, community benefit activities that are currently being offered, community volunteer activities that are currently being offered, so we're looking for maintaining those or enhancing them.

MR. CROCKETT: Three parts, in terms of the charity care, the second part the community benefit, and the third is the volunteer.

As are stated in our APA, that we will maintain the charity care policies, and, so, yes, the confirmation associated with that.

The second part was the community benefit program. As was testified today, part of the community benefit that currently Waterbury is given is grant related, and the Ryan White was an example of that, and some of those funds, in some of those instances, the funds can be transferred to a for-profit and, in other instances, they're not able to.

Waterbury is in the process of

transferring those that are not able to be transferred to a for-profit to other organizations, and we're supportive of that, as well. For those areas that Waterbury can continue to receive the grant funds for, then Prospect will continue those community benefits associated with that.

MS. MARTONE: That's fine, and then we would just ask for a list of the community benefit activities that would be continued, if you receive the grants for that money.

MR. CROCKETT: Correct. As it relates to the volunteer, Jon, you can correct me if I'm wrong, but I believe that we're going to continue in the same fashion.

MR. SPEES: Well, actually, we would love to be able to continue the volunteer program, but we actually believe that it may be challenging to receive the services of volunteers as a for-profit entity, so we've been looking at ways that we may be able to continue the volunteer services, but we may actually be precluded by the employment law from doing so.

MS. MARTONE: That's understood. Precluded from that. But, also, the concern is the five-year limit and why you would only maintain the policies

for five years, unless you were going to increase the policies after five years.

MR. CROCKETT: Once again, it was to match up to the APAs related to the commitment of services and to be consistent throughout.

MS. MARTONE: Okay. Also, we had discussions and there's public comment regarding having a community ombudsman on board to truly represent the community, especially on the local Board, so is there a concern that Prospect has with having a community ombudsman on the local Board representing the community?

And it sounded like from public comment today they would really like a more diverse Board and really representing the people in the community.

MS. VOLPE: Can I just ask for a point of clarification? So the community ombudsman, if they were on the Board, serving as a Director on the local Board, what different or additional role would they have as an ombudsman?

MS. MARTONE: I don't think it would be a different role. It would just be someone, who was truly picked from the community, not by the hospital, not by members of the hospital. Maybe a First Selectman would decide a community member to be on the Board.

MS. VOLPE: So I think we're open to it, but, again, who would be selecting that person? We talked a lot about the composition of the local Board, so that's what I'm saying. Are you asking for a community Board person?

MS. MARTONE: Yes.

MS. VOLPE: And, so, their role would just be to serve as a Board selected from what in the community? What's the --

MS. MARTONE: Correct. Like I said, it could be by the First Selectman. It's someone, who is representing the community truly and representing their needs and bringing that to the Board and bringing that back to the community.

MS. STROMSTAD: Could I just comment on this? I think that the present Board of Directors of the Greater Waterbury Health Network would all say they represent the community.

First of all, you want to have, you know, a good cross-section of Board members, which I believe we do. These people have volunteered for years. They give up their time and are very concerned about the delivery of health care, so I think they are truly representatives of the community.

The other thing that I think is really important to recognize is that your Board needs to come as great advisors, so we give a lot of thought to the makeup of our Board. Not all of them are the same. They are different. They come in with different perspectives, different skills, and having that healthy balance for your Board is really important.

I'm a little concerned about, you know, a wider body just kind of like saying take this person, when it really needs to fit into the overall Board and skill set that we need. It could work.

MS. MARTONE: Okay. That's fine. Okay and the last area that has been discussed at other hearings is having an annual public forum, and that would be held yearly, and Prospect would attend, and it would give the public an opportunity to voice any concerns and issues, as well as give Prospect an opportunity to share with the community their activities, and Prospect did confirm that at a previous hearing.

MR. CROCKETT: That's confirmed, yes.

MS. MARTONE: Okay.

MR. REARDON: I'd just like to make one correction. Mr. Rawlings kind of made a comment that we didn't want to talk to the community, and I think that's,

in all due respect, a total mischaracterization.

We've met a couple of times, as Steve Shrag and Reverend Thompson said, with Naugatuck Valley and with the community, and we're glad to keep meeting with them. We're glad to have input from them and meet with the NAACP.

We have many of the same goals. In fact, as you go down the list, they're almost all the same. Our concern had been signing specific agreements with a multiple set of groups, beyond having an agreement with ALCO(phonetic) which could be enforced, and conditions from the State and working with our Adviser Board.

MS. MARTONE: We understand that. Thank you. Okay. Steve?

MR. LAZARUS: All right. Steve Lazarus. I just have a couple of questions. Can you confirm that in the draft APA it was stated that the Applicants will follow the same general community benefit standards, and those would include -- they would participate in the Medicare and Medicaid program and accept all Medicare and Medicaid patients, accept all emergency patients, without regard of ability to pay, maintain an open medical staff, and provide public health programs and education benefits to the community and generally promote public health

wellness and welfare to the community?

MR. REARDON: That's confirmed.

MR. LAZARUS: Okay, thank you. And really my last question is can you confirm that PMH would spend one percent more than the amount of what Waterbury Hospital spent in fiscal year 2014 for the first three years of post-closing in both the financial assistance and certain other community benefits at the cost and the community building activities?

MR. SPEES: Yeah, that's not part of the APA, and we've had this conversation. I just want to clarify, because we're talking about terms that are very similar sounding.

There's community building, there's community benefit, and they're significantly different, so if you're referring to the community building activities, that answer would be yes.

MR. LAZARUS: What about the financial assistance and, also, certain other community benefits?

MR. SPEES: Well didn't we talk about the community benefits, that we would provide a list that you asked for of those programs that would continue?

MR. LAZARUS: So the one percent that you have referred to, that was only for the community

building activities, in reference to that?

MR. SPEES: Correct.

MR. LAZARUS: Okay, nothing else?

MR. SPEES: Well we've committed to maintain the charity care policies, and, so, as part and parcel of that would be community -- a significant amount of community benefit there. We've committed to maintain the clinical services, which are significant, and we've talked about providing a list of the other types of community benefit services that we expect to continue, so I'm not sure what we're missing in that group.

MS. MARTONE: I think we're just trying to distinguish between the two, as well.

MR. SPEES: Yeah.

MS. MARTONE: And it's important to the Department that community benefits are made a priority in this proposal. We realize the fact that you might not be able to provide some of them, because there might be a grant issue, but it is very important that the community benefit activity that has taken place over the years that Waterbury has done we would like to have that maintained, if not, improved, but maybe you'll be improving it in other areas, because of the grants that you receive, so that's something we would need to look at.

MR. LAZARUS: So just confirming, this is for a three-year period, not a five-year period?

MR. SPEES: Correct.

MR. LAZARUS: In this instance.

MR. SPEES: Correct. Still, though, I'm not clear on exactly what commitment you're looking for, because of the nature of the language around what constitutes a community benefit and what constitutes community building, and I'm concerned that it's overly broad.

MR. LAZARUS: So it's something that we'll have to clarify as we move forward?

MR. SPEES: Yeah.

MR. LAZARUS: All right, thank you. I'm going to turn it over to Carmen for some financial questions.

MS. CARMEN COTTO: Carmen Cotto, and I'm going to direct my questions mainly to Mr. Aleman and Mr. Spees.

My first question is related to we had asked you to provide us some information related to some issues prior to this hearing, and I'm just going to ask you a question related to your responses on those issues that we received last week.

The first one is related to issue number two. That's on page one and three of your responses from last week on April 27th. It's with respect to the pending purchase of Crozer-Keystone Health System in Pennsylvania. We just wanted to ask you does PMH anticipate to close that transaction, ECHN transaction and Waterbury transactions, approximately at the same time? When would you intend to close those transactions?

MR. ALEMAN: I would anticipate those would all be closed certainly within the next 120 days. Crozer-Keystone in Pennsylvania is going through the regulatory review process, as well. They're all on -- I think you're certainly aware of the timelines between Waterbury and ECHN. Crozer-Keystone we anticipate closing early summer.

MS. COTTO: Early summer. And, then, for ECHN? Do you have an estimate of the closing days?

MS. VOLPE: So we're expected to receive final approval on or about June 10th, but we still have to get licensed, all in the facility have to get licensed, so that isn't within your control or ours necessarily, so some of the closing date is going to be dictated by how quickly we can get the licensure applications complete and reviewed and gone through at a

separate division of your department, so, in terms of a definitive close date, I think everybody wants it as soon as possible. Prospect does, Waterbury does, ECHN does, but I think, in reality, some of it is going to be dictated by the regulatory process, so I think we can certainly say, upon regulatory approval, all regulatory approvals, AG, OHCA, licensure, you know, we can commit to some time period thereafter.

HEARING OFFICER HANSTED: It's fair to say, just for these discussion purposes, that Pennsylvania will close a good amount sooner than Connecticut, if approved.

MR. ALEMAN: I've come to learn you never know.

HEARING OFFICER HANSTED: Right. I won't hold you to it.

MR. ALEMAN: Right now, it's currently anticipated to do so, and let me just kind of take it to the next step. When all transactions from a regulatory standpoint were able to close, we have the financial wherewithal to close on all three, so there's no concerns on that behalf from our standpoint.

MR. SPEES: But just to make sure, there's more than just regulatory to closing a transaction, so we

also have lots of contracts to get assignments on, and we have get payer contracts, and we have to get landlords to consent to assign leases, so it's a very significant amount of work, and we are holding weekly meetings, and, as Michelle said, we're trying to move as quickly as we can to be in a position to close, and they are all sort of lining up to be approximately the same closing schedule, but it would be hard to predict the exact date.

HEARING OFFICER HANSTED: Let me boil this down really to a pinpoint here. If all of these transactions were to close on the same day, would there be a financial constraint for PMH?

MR. ALEMAN: The answer is no.

HEARING OFFICER HANSTED: Thank you.

MR. SPEES: It would be a challenge.

MR. ALEMAN: A logistical challenge, not a financial challenge.

DR. LEW: But a no.

MR. SPEES: I can actually predict that that will not occur.

HEARING OFFICER HANSTED: I'm sure I could, also.

MS. COTTO: Okay. With that said, then could you provide us with a report that states how these

transactions will be financed, a specific report that states how it will be financed, and shows that you really don't have a problem financing these closings?

MR. ALEMAN: Sure.

MS. VOLPE: So would that be Late File No. 1?

HEARING OFFICER HANSTED: That will be Late File No. 1.

MS. COTTO: Okay. Let me see. I have another question on issue number five, page six and 38. The responses indicated that -- let me give you the exact statement. It indicates that there are several grants that will continue to flow directly to post-closing Waterbury Hospital.

Our request is could you provide us a list of those grants that will flow directly to Waterbury Hospital post-closing?

MR. ALEMAN: Yes.

MS. COTTO: Okay.

HEARING OFFICER HANSTED: That will be Late File No. 2.

MS. VOLPE: So just for point of clarification, the list of grants that would flow to Waterbury Hospital post-closing or pre?

MS. COTTO: Post-closing.

MS. VOLPE: Post-closing?

MS. COTTO: Yeah. I just have things to clarify, in terms of the numbers. To the letter of intent that you submitted in April in 2015, the purchase price shows $45 million. Through the APA, the draft that we have on file, indicates 31.8 for the purchase price, and, today, you're back to the 45 million. I just want to confirm is it 45 million, the purchase price?

MR. SPEES: Yeah. The difference there is the working capital, so it's 31.5, plus the value of the working capital at closing, and that fluctuates from month-to-month, but, based on the most recent month, it actually pencils to slightly more than $45 million, so that's the difference in those two data points.

MS. COTTO: Correct, because the APA indicates, though, that it's 31.8, plus the net working capital.

MR. SPEES: Correct.

MS. COTTO: And, as of September 31st, it was at 4.6, so I'm just trying to get to the -- so what you're saying is, between the time that you finalized, gave us, produced a draft of the APA in October and as of today, then the net working capital has changed that much

and increased from 4.6 to the difference between the 31.8 and 45 million? Is that what you're saying? I'm just trying to clarify the difference here.

MR. SPEES: Sorry. I'm not following the dates and data points. So the working capital changes on a monthly basis, and it could swing, you know, millions of dollars between one month and the next month.

MS. COTTO: Okay.

MR. SPEES: And the purchase price is dollar-for-dollar, based on what that value is.

MS. COTTO: So it fluctuates that fast?

MR. SPEES: It does fluctuate a fair amount.

MS. COTTO: Okay, so, it is 45 million. And the capital commitment is still seven years, because I heard five years in other --

MR. SPEES: This transaction is seven years.

MS. COTTO: Seven years for the capital commitment?

MR. SPEES: That's correct.

MS. COTTO: Could you provide us with an update on the joint venture's interest? Have the transfers finalized?

MS. STROMSTAD: Yes, we'll do that. We'll confirm that we have all the consents from our joint ventures. Is that what you're asking?

MS. COTTO: Yes. I'm just wondering if they're already done, as of today, or are you still waiting?

MS. STROMSTAD: No. We still have some Board meetings that are going on.

MS. COTTO: You are?

MS. STROMSTAD: Yes.

MS. COTTO: Okay, thank you. And then, for PMH, what's your credit rating, as of right now?

MR. ALEMAN: It hasn't changed.

MS. COTTO: It hasn't changed since last year?

MR. ALEMAN: That's correct.

MS. COTTO: 2015?

MR. ALEMAN: That's correct.

MS. COTTO: So it's still B?

MR. ALEMAN: B.

MS. COTTO: B-1 plus?

MR. ALEMAN: Yes.

MS. COTTO: Okay and could you provide us with an updated version of the net proceeds and flow of

funds calculation that you have provided to us on page 1419? That one is only until September 30th.

We need you to provide us with a revised version, the same way that you did for ECHN, because we received a revised version, with two columns that indicates 9/30/15 numbers, and then the most recent numbers for March.

MR. ALEMAN: Yeah, we can do that.

HEARING OFFICER HANSTED: That would be Late File No. 3.

MS. VOLPE: So you want an update to Bates stamped Exhibit 1419?

HEARING OFFICER HANSTED: Correct.

MS. COTTO: Right. Yeah. Just update that one, and include two columns. Still keep the 9/30, and then also add as of March 1st, like you did for ECHN. Same request.

MR. ALEMAN: That's fine.

MS. COTTO: And that's it. That's it for me. No more questions. My apologies. I'm sorry. My apologies. I do have another document here, but it's not this long. It's just two questions. I'm sorry.

In the testimony on page 1628, 29, you talk about, and you talked about it through the

presentation, about the amendments to the APA and the LOI to favor Waterbury, to help Waterbury to this proposal.

Could you tell us when could you file that to us, a copy of that? Because you indicated that would be filed to OHCA.

MR. SPEES: Yeah, so, we just received a draft of the amendments last Friday and haven't had much chance to focus on it, but I would say within a couple of weeks we should be able to finalize that, if that's acceptable?

MS. COTTO: Okay.

HEARING OFFICER HANSTED: That will be Late File No. 4.

MS. VOLPE: And there's just a question about clarification. You're looking for any changes that may occur to the APA or the LOI?

MS. COTTO: Correct.

MS. VOLPE: The amendment to the LOI and any change to the proposed draft?

MS. COTTO: Correct.

HEARING OFFICER HANSTED: Correct.

MR. SPEES: Yeah, and I think, technically, we have to amend the LOI to attach the new APA.

MS. VOLPE: Very good.

MS. COTTO: I'm done. I'm all set. Thank you very much.

HEARING OFFICER HANSTED: We're all set.

MR. ZINN ROWTHORN: Okay. We're going to try very hard to not duplicate what's been asked already, either here or in other hearings. Attorney Salton, do you have some questions?

MR. HENRY SALTON: Yeah, I do. I have a couple of questions regarding the capital commitment, the reinvesting in the community.

The time frame for completing the capital commitment investment in the community for ECHN is five years. The Waterbury application indicates seven years. Can you explain why there's a difference in the two commitment periods?

MS. STROMSTAD: I can explain that. Our transaction with whoever was first was seven years, and, when we started our discussions with Prospect, we just adopted the same thing, and the reason it was seven years is that we felt that we didn't want to be pushed to spend money before we were ready to implement it.

There's nothing that you can do wrong. I've been in this industry for a long time. To implement

something that you throw a great deal of investment in and then don't have the time and the intention to make it work for you, so we were very comfortable with the first transaction of taking that bullis of money and spending it over seven years.

MR. SALTON: Okay. There were some comments earlier today about the condition where there's an adverse -- legal requirements adopted that's prejudicial for profits, and, in the application, unlike ECHN, which provides for a deferral of the investment, your agreement in the application indicates that you can base they're relieved of your commitment, and then there's a process for coming to some mutual agreement, and I just want to get clarity on what your position is on that provision now.

You're going to just look at what we're going to suggest, or are you standing by that, because there's a significant difference between those two positions?

MR. SPEES: Yeah, so, just to clarify, recognize that the language in the Waterbury purchase agreement is more broad, in terms of being able to be relieved of the capital commitment, and, as I testified earlier, we're willing to not have any relief from the

capital commitment, so that it would be a firm dollar commitment.

In addition, in neither agreement is there a specified time over which the capital commitment could be deferred in that circumstance, and we're open to limitations on the time commitment that that capital commitment could be deferred.

MR. SALTON: Okay. Moving to the quality improvement program, because I don't want someone, who is new to the entity, not have a chance to speak.

I'm actually going to ask the first question to the President and not to you. So this is a draft program that I guess was submitted initially April 20th with the late filings for ECHN. What is the company's perspective on their commitment to this program? Is this something that's sort of just it's an idea that's out that we're looking at, or is there a commitment to going forward with this, or is there major revisions on off stage coming forward?

DR. LEW: Sure. I'll speak generally to this, Henry, and then, if Von wants to add anything. So, you know, we brought in Debbie Berry, because of her credentials, and she shared her expertise in prior dialogue, and she also shared what she referred to as the

draft and the outline of what our commitment is going to be, so our commitment is that's a start, okay?

Our commitment is to build on that, and, as you've heard, we support the current effort at Greater Waterbury in their efforts to be a high-reliability organization, and, as I shared with you the last time we met, how I was embarrassed.

And the fact that we were moving directionally, as Von shared with LA, in having the conditions relieved, we've made significant progress already in California and now with the addition of Debbie to set a path for us to excellence.

And to share a line from Neil, who was very colorful in his presentation, to be great, and that's our commitment.

If you want anything specific, I can have Von speak to it.

MR. CROCKETT: Yeah. We've actually -- the word draft is really meant more in terms of, once we start working closer with ECHN and Waterbury and potentially the Philadelphia organization, as well, then we would fine tune the organizational chart.

We've already started actually filling the positions within the draft that you've already seen, and

I anticipate that, with Dr. Lew's support and others, the program will be adopted, and it would only be minorly tweaked.

MR. SALTON: So, at the corporate level, we should see this, if not, some additional improvement on what's been submitted?

MR. CROCKETT: That's correct.

MR. SALTON: Okay and looking at what you've presented, as far as you're talking about substantial data systems and collection, integration of a dashboard, lots of staff, is there a financial commitment by the company to implement all of these things?

DR. LEW: Yes.

MR. SALTON: Okay and I notice that you've submitted CVs for three folks, and I understand, Debbie, what you're going to be doing, what who are the other, what are the roles of the other folks going to be in this org chart, as far as which positions are they going to hold, so that we know whose credentials we're looking at?

You want the names? One is Candace Peters.

MS. BERRY: Candace Peters, she is assigned as the AVP of Regulatory and Accreditations. She's probably going to move under that VP Regulatory and

Accreditation for our clinical practice person. I don't know that yet, but she's going to move within that position. What other positions? Oh, Thedosia. Oh, I'm very excited about Thedosia. She is our Senior CNO. One thing that I'm very committed to is improving the clinical excellence of our nursing practice, so Thedosia is going to lead that up for the organization. I met with her the first time. Very impressed.

MR. CROCKETT: And, for clarification on the org chart, that box doesn't exist right now. We're going to be adding it in, and that's part of the minor modification to the program that I was speaking to.

MS. BERRY: Yeah.

MR. SALTON: Okay.

MS. BERRY: Because, at the time I created that, I had not met yet with Thedosia. I can never say her name right. Thedosia. So I didn't put her in there, but I'm very excited about that role.

MR. SALTON: In the org chart that is the corporate officers for Quality, how many of those positions are filled?

MR. CROCKETT: At the moment, you know, we haven't spoken with the individuals that I think clarified it with them, but we anticipate, Debbie and I,

that two of those positions are going to be filled with staff in-house, then we'll be looking within either the ECHN, Waterbury and Crozer facilities in filling the other roles, and, if not, then looking external, but we anticipate two of those roles will be filled internally.

MR. SALTON: Okay, so, in the org chart and in the materials you submitted, there are these councils. What's the relationship between the local Board, which has Quality Assurance responsibilities, and these councils? I'm not sure the councils are part of the corporate entity, or they're perceived as being within the hospital.

MS. BERRY: That would flow up into, that local quality would flow up into the regional.

MR. SALTON: So is the council different from the local Board?

MS. BERRY: At the time that I created this, I didn't know that there was a local Board. Pretty much, your local Board is going to go through your Quality, 3 MAC 3 Board (phonetic), and it will go up to the regional, and then to the company.

MR. SALTON: If you guys have a vision of how you're going to revise this, I know this was a preliminary draft and now you know the local Boards are

there, could you guys submit an updated organizational chart, so we can make sure that we understand?

In addition, I assume that the late filings that were done in ECHN 1410, three of those things that describe the program, those are going to carry over to Waterbury?

MS. BERRY: Um-hum.

MR. SALTON: So to the extent there's some update to make sure that everything is integrated, because you have now the commitment letter, which we got today.

MR. ZINN ROWTHORN: Yeah and I'll just mention we have left the record open indefinitely with respect to the immediate jeopardy matter, so that we can have all documents related to those be submitted.

I think you should consider, with respect to amendments to the organizational chart, as that evolves over time, that our record will remain open for that, so we'll have the most current information up through our time of decision, if that's okay.

MR. CROCKETT: That's acceptable.

MR. ZINN ROWTHORN: Thank you.

MR. SALTON: Part of what you proposed is a gap analysis at the local hospitals. Do you have a

sense of when that's going to take place, and then would a gap analysis be presented to the local Board?

MS. BERRY: Those are based on, when I spoke to the gap analysis, those were based on initiatives. For example, if we wanted to decrease pressure ulcers, we would bring together a work team, where that work team comes in with folks, who are experts in wound care, folks that are as close to the bedside as we can get, then they would write an initiative, create an initiative that has a tool kit that would help all the sites get there, but the first piece of that, when I send out an initiative, would have a gap analysis.

So if Waterbury already has all those components, they just sign off that they have those components and we're done, so that's the gap analysis.

I don't want everybody to do something that they've already done, or if they have something better, you know, I don't want them to go back to something we're doing, so that's the purpose of the gap analysis.

MR. SALTON: Once you create, fully fund and invest with staff at the corporate quality level, there's going to be some process, where you now turn to your hospitals and say, okay, we want to get a snapshot

of where you are and what you're doing or not doing?

MS. BERRY: Correct.

MR. SALTON: Okay.

MS. BERRY: You know, how are your outcomes, comparing what you're doing with your outcomes, as well.

MR. SALTON: Do you perceive, as it's now laid out, like, for example, you have one data analyst laid out, that you're going to be able to get all this done for 17, 19 hospitals with the staffing that you propose?

MS. BERRY: I think that what we propose is a basic initial program that, as we bring in volume, we'll most likely have to expand.

MR. SALTON: So you'll scale it up to the volume of work?

MR. CROCKETT: Correct.

MR. SALTON: In the commitment letter you signed with Waterbury, there is a provision, this is the Late File T, I think it is, and this is my last question, so you can smile now, Mr. Crockett, there's a commitment to provide adequate financial resources to assure the facility issues related to quality and patient safety are addressed timely and not to be limited to the operating

funds of the post-Waterbury Hospital.

I don't recall, and I don't have it in front of me, that the same commitment was made to the other hospitals. Is that commitment going to be made to the other hospitals, as well?

MR. CROCKETT: I believe that it was, but in the event that it wasn't, then we would make the same commitment.

MR. SPEES: Yeah, that one is actually slightly different and it evolved, because this was the second kind of go after, so the answer is, yes, we would be willing to do that.

MR. GARY HAWES: Okay. I just have a couple of questions. As you know, I do most of the charitable stuff, and we haven't had a lot of conversation about that. I only have a few questions.

It doesn't look like Mike is here. I'm not sure if we need him for these, because I know Mike has worked on some of this, so if you don't know the answer, then we'll just take it as a late file.

In looking at the new foundation, so there's a new foundation going forward that's going to handle the restricted charitable assets and any net assets that remain, in the makeup of the Board it talks

about a preference or a certain number that need to either work or live in the Waterbury area to serve on the Board of this charitable foundation, and I guess my question was why will not all the trustees of this foundation either work or live in the Greater Waterbury area?

HEARING OFFICER HANSTED: If you could just come up to the microphone? Thank you.

MS. ANN ZUCKER: The thought was not to necessarily limit it to people in the Waterbury area, although that's the natural result, but to the extent that there is somebody, who perhaps had a connection to the Waterbury office and has a particular expertise that we might want to tap into, you wouldn't want to be precluded from including that person.

MR. HAWES: Waterbury Hospital's proposal about their needs going forward post-transaction discuss and propose, excuse me, that non-restricted funds that are coming in they're going to be used to pay off debts over time, and, so, not all of the funds that exist are going to be transferred to the new foundation right away, and, so, the question I have is how does Greater Waterbury contemplate the transactions for restricted funds happening, moving to the foundation the timing of

the move of restricted funds that can't be used by Greater Waterbury to pay off their obligations, as compared to those, which can? Is it two waves of approximation actions that you're thinking about, or are you looking at the post-Greater Waterbury entity post-transaction, holding onto those and doing it all at one time once things are paid off?

MS. ZUCKER: We haven't made a final decision on that. It may be that we need to do two waves.

MR. HAWES: Okay. The summary of the gift documents and the value of the gift documents, no surprise, it's a little out of date now, so if we can get current numbers on that, and that's a request that we've made to ECHN, so I'm sure that's not a surprise going forward.

And not that I really have an interest in getting into community benefits or community building, but there was a report asked for for funds that will be able to continue to flow to the for-profit that's going to be reported.

Our office would be interested to have a report of those funds, which cannot flow to the for-profit and are going to have to have the work around, and

I think the best example, I'm not going to remember the name of the fund, but the Ryan White fund and that program, so others that fall into that category how Greater Waterbury is trying to work around that to still provide that benefit, but just not through the for-profit.

MS. STROMSTAD: We will have that to you.

MR. HAWES: Okay. That's it for me.

MR. ZINN ROWTHORN: That's it for the Attorney General's Office.

HEARING OFFICER HANSTED: Okay. Before we adjourn, are there any other members of the public, who would like to give comment on the proposal?

Okay, with that, I would like to thank everyone, who attended this evening, and the hearing is adjourned.

(Whereupon, the hearing adjourned at 7:30 p.m.)

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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 10th day of May, 2016.

Paul Landman
President

Post Reporting Service
1-800-262-4102

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, May 19, 2016 11:09 AM
To: Greer, Leslie
Cc: Martone, Kim; Riggott, Kaila; Roberts, Karen; Cotto, Carmen; Hansted, Kevin
Subject: FW: ECHN - Scheduling [CTAG-CTAG.FID647701]
Attachments: 2016-05-19 ECHN - 2d scheduling letter.PDF

Leslie,

Please add it to the original record.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Hawes, Gary W.
Sent: Thursday, May 19, 2016 9:38 AM
To: jonathan.spees@prospectmedical.com; Dennis P. McConville (dmcconville@echn.org); 'rmatthews@wiggin.com'; Agsten, Melinda A.; mmv@bvmlaw.com
Cc: Martone, Kim; Lazarus, Steven; Zinn-Rowthorn, Perry A.; Salton, Henry A.; Turner, Cheryl A.
Subject: ECHN - Scheduling [CTAG-CTAG.FID647701]

Please see the attached letter that addresses the schedule for the Proposed Final Decisions and the time for comment on the Proposed Final Decisions. Thanks.

Gary

Gary W. Hawes | Assistant Attorney General | Office of the Attorney General
55 Elm Street | P.O. Box 120 | Hartford Connecticut 06106
T: 860.808.5020 | F: 860.808.5347 | gary.hawes@ct.gov

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STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
ACTING COMMISSIONER

May 19, 2016

VIA ELECTRONIC MAIL ONLY

Jonathan Spees
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10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Darlene Stromstad, FACHE
President/Chief Executive Officer
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06708

Re: OHCA Docket No. 15-32017-486 and OAG Docket No. 15-486-02 – Schedule for Proposed Final Decisions and Comments

Dear Mr. Spees and Ms. Stromstad:

This letter sets forth the schedule for the issuance of the Proposed Final Decision and the comment period for those decisions in the hospital conversion dockets OHCA Docket No. 15-32017-486 and OAG Docket No. 15-486-02 currently pending in the Department of Public Health, Office of Health Care Access ("OHCA") and the Office of the Attorney General (the "OAG"). The Applicants for both these dockets are Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH").

The OAG and OHCA will issue their Proposed Final Decisions on or before **June 24, 2016**. Comments from the Applicants and the public will be due on or before **July 1, 2016**. And, as previously agreed upon by all parties in the scheduling letter dated May 6, 2016, the OAG and OHCA will issue their Final Decisions in these dockets on or before **July 15, 2016**.

Should you have any questions regarding these dates, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General

Very truly yours,

Kim Martone
Director, DPH/OHCA

cc: Steven Lazarus (via electronic mail)
Ann Zucker (via electronic mail)
Michele Volpe (via electronic mail)

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Friday, June 03, 2016 12:03 PM
To: Lazarus, Steven
Cc: Ann H. Zucker; Cotto, Carmen; Greer, Leslie; Jennifer O'Donnell; Michele Volpe
Subject: RE: Follow Up on the Late Files regarding DN: 15-32017-486
Attachments: GWHN PMH Late Files 1 and 5 (5.24.16).pdf

All:

Pursuant to Michele's email below, attached please find Late Files 1 and 5 that were originally sent May 24, 2016.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
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From: Michele Volpe
Sent: Friday, June 03, 2016 12:01 PM
To: Lazarus, Steven <Steven.Lazarus@ct.gov>
Cc: Ann H. Zucker <AZucker@carmodylaw.com>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Kathleen Gedney <kgg@bvmlaw.com>; Jennifer O'Donnell <jlo@bvmlaw.com>
Subject: Re: Follow Up on the Late Files regarding DN: 15-32017-486

Steve we will resend. Thanks

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On Jun 3, 2016, at 11:58 AM, Lazarus, Steven <Steven.Lazarus@ct.gov> wrote:

Hi Michele,

We verified and the email sent with the Late Files only mentions and includes Exhibits 2 onwards, was Exhibit 1 sent separately? We may have missed it.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053
<image001.jpg>

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, June 03, 2016 11:48 AM
To: Lazarus, Steven
Cc: Ann H. Zucker; Cotto, Carmen; Greer, Leslie; Kathleen Gedney; Jennifer O'Donnell
Subject: Re: Follow Up on the Late Files regarding DN: 15-32017-486

Ok great thank you. We can easily resend if that is less time consuming for you. Let me know.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On Jun 3, 2016, at 11:46 AM, Lazarus, Steven <Steven.Lazarus@ct.gov> wrote:

> Michele,
>
> Let me have Leslie check the paper file to make sure before we move forward. I'll get right back to you.
>
> Steve
>
> *Steven W. Lazarus*
> Associate Health Care Analyst
> Division of Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue

Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053
<image001.jpg>

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, June 03, 2016 11:45 AM
To: Lazarus, Steven
Cc: Ann H. Zucker; Cotto, Carmen; Greer, Leslie; Kathleen Gedney; Jennifer O'Donnell
Subject: Re: Follow Up on the Late Files regarding DN: 15-32017-486

Hi Steve
A late file response for question 1 was submitted and answered the question presented. Did you receive it? We can resend? Was it deficient in some respect?Please provide clarity on your request. Thank you.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On Jun 3, 2016, at 11:08 AM, Lazarus, Steven <Steven.Lazarus@ct.gov> wrote:

> Good Morning Michele and Ann,
>
> Can you please provide me an update and a timeline about the missing late file (see below in yellow highlight) from the late files provided for GWHN/PMH proposal last week?

1	Report Re: How PMH Will Finance All Transactions, ECHN's, GWHN's and CKHS' (list total cost, total cash needed at closing, funding source and dollar amounts available to cover the cost and cash needed at closing)

> Thank you,
>
> Steve
>
> *Steven W. Lazarus*
> Associate Health Care Analyst
> Division of Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue

Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

Late Files 1 and 5

Greater Waterbury Health Network, Inc.
Prospect Medical Holdings, Inc.

OHCA Docket Number 15-31217-486
Attorney General Docket Number 15-486-02

May 24, 2016

Late File 1 - Report Re: How PMH Will Finance All Transactions - ECHN's, GWHN's and CKHS' (list total cost, total cash needed at closing, funding source and dollar amounts available to cover the cost and cash needed at closing)

Prospect Medical Holdings *5/10/2016*

Late File Submission: Inquiry as to funding sources for acquisitions

Sources		**Uses**	
		Projected Cash at Close	
Financing (June 2016)	$ 155,032	Crozer Keystone Health System	$ 155,032
Cash from Existing Operations	28,000	Eastern Connecticut Health Network	28,000
Cash from Existing Operations	-	Greater Waterbury Hospital Network	-
	$ 183,032		$ 183,032

Footnote

Prospect Medical Holdings projected cash at close 7/31/16	+	*80,000,000*
Full Revolver Availability (balance to be paid with June '16 financing)		*60,000,000*

CT8631

Late File 5 - Updated PMH Quality Organizational Chart

Introduction

Philosophy: To ensure that our patients receive the right care, at the right time, in the right setting, with efficiency and compassion.

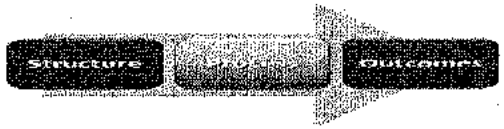
Mission: Above all, we are committed to quality in all aspects of healthcare delivery, including:

- Striving for the best possible patient outcomes
- Maintaining the highest standards of patient safety
- Acting with integrity at all times
- Promoting open communication
- Collaborating to better serve the healthcare needs of our communities

Purpose: The PMH Quality and Patient Safety Program will focus on continuous enhancement of quality and safety for all we serve. Every employee plays a crucial role in ensuring patient, visitor and employee safety. We will work to reconnect quality and patient safety to clinical care thereby promoting high quality, safe, effective and efficient care. Additionally, the program will strive to build a just culture of safety by implementing strategies to reduce medical errors. Reducing risk and ensuring safety requires increased attention to systems that prevent and mitigate errors. The corporate quality and patient safety team will work with hospital to provide appropriate solutions to ensure best practices, resulting in quality patient care and service.

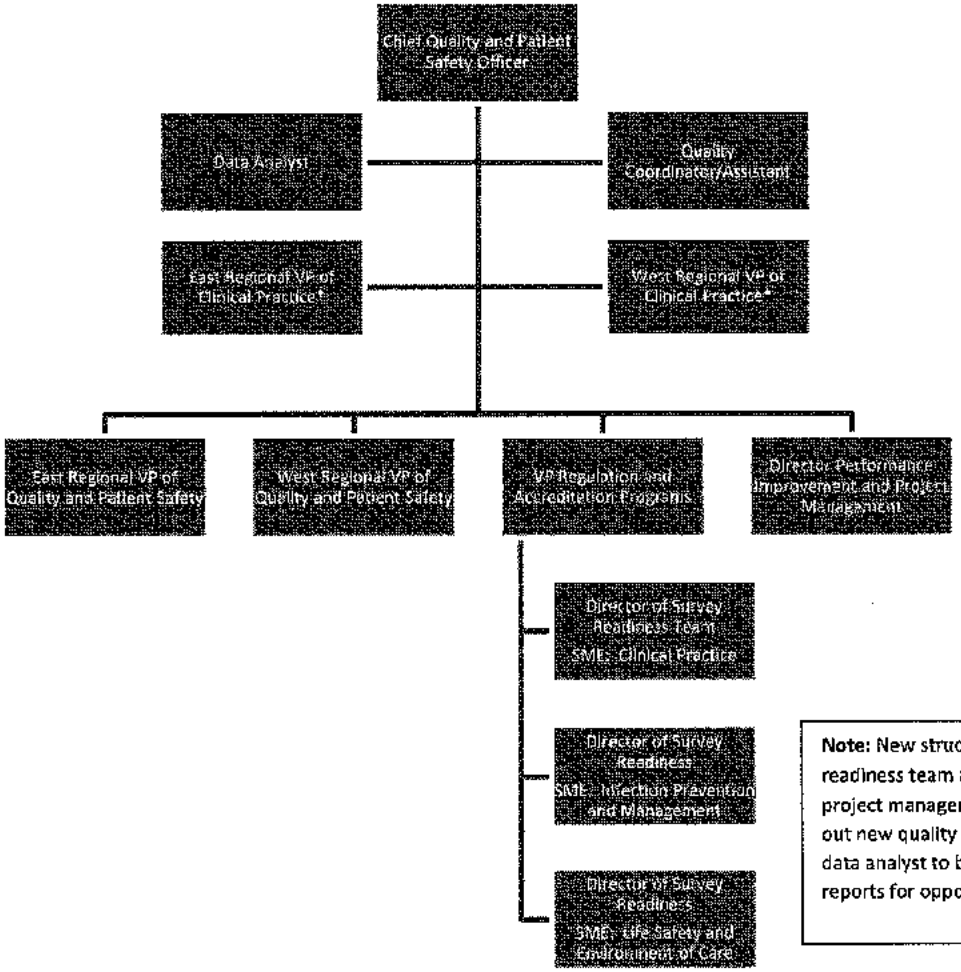
Goal: Build corporate and regional structures and processes necessary to become a high reliability organization promoting patient-focused, high quality, safe, compassionate, efficient, and effective care.

Model: We will achieve our mission and purpose through building and sustaining a robust quality and patient safety program at all levels of the organization. The key elements of this program will include: innovation, service, education, transparency, and patient partnerships. We will be using the Donabedian Quality of Care Model as our framework for building the program. Our initial focus will be on creating the corporate structure to enhance our ability to build processes and achieve outcomes.



C18833

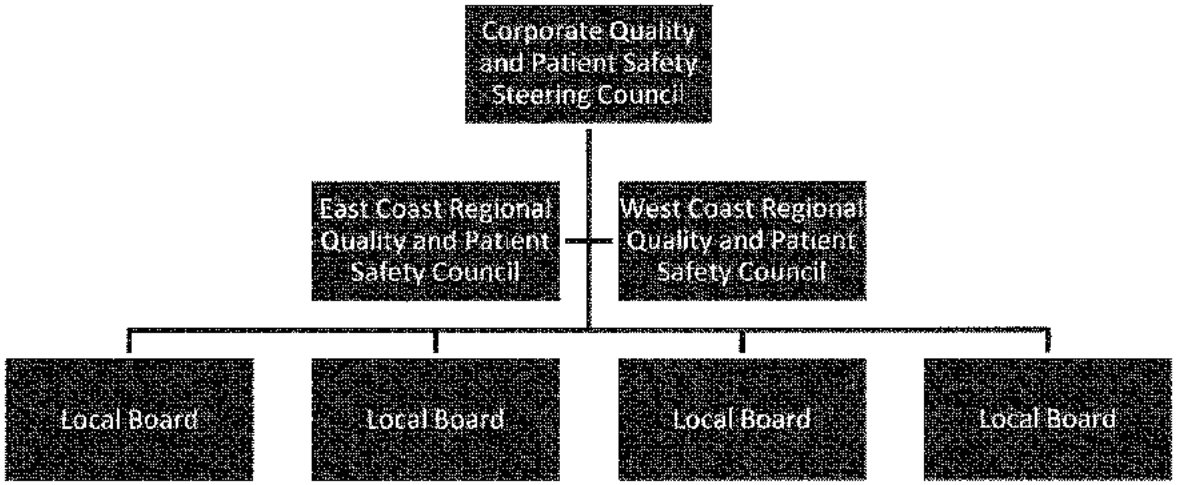
Corporate and Regional Quality Performance Improvement and Patient Safety Structure



Note: New structure will include a mobile survey readiness team and a performance improvement project manager to assist with designing and rolling out new quality and patient safety initiatives and a data analyst to build and interpret standardized reports for opportunities.

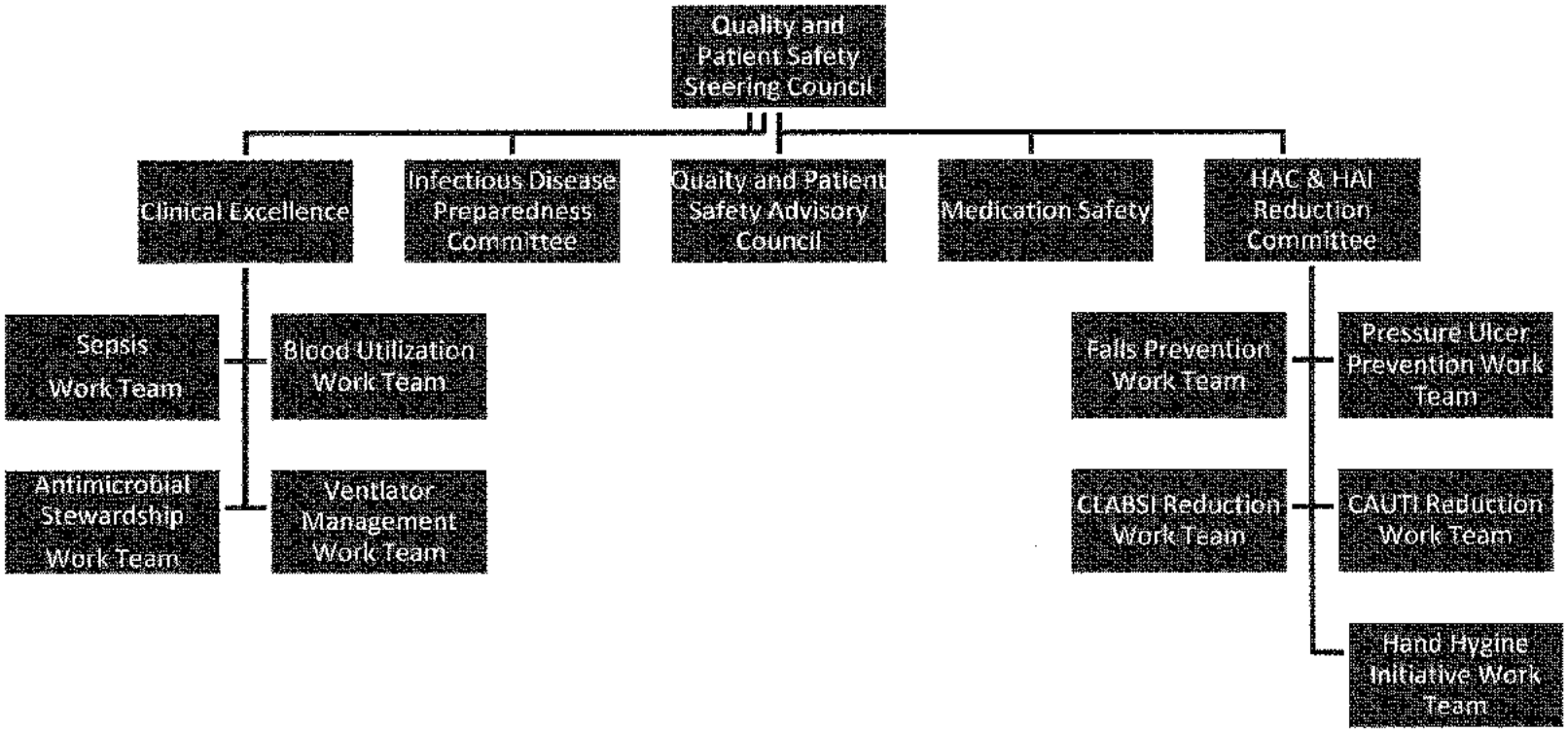
C1834

Quality and Patient Safety Communication and Reporting Structure



Note: Local Board will report up through the appropriate Regional Council to the Corporate Council with final reporting to the Corporate Board of Directors.

Corporate Quality and Patient Safety Steering Council



Note: Suggestions for potential committees and work groups under committees. These may change based on the finalized Quality and Patient Safety agenda and strategic plan. Committees and work groups may be added, deleted or changed based on organizational needs and priorities.

Corporate Quality and Patient Safety Steering Council Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the Regional Councils
- Assists with the development of the Corporate Quality and Patient Safety agenda and strategy, incorporating regional and local input
- Provides oversight for execution of the Quality and Patient Safety agenda and strategic plan across the Company
- Prioritizes Quality and Patient Safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from chartered committees and work teams for implementation across the company
- Engages in identifying ongoing quality and patient safety performance improvement opportunities
- Ensures follow-up on regional initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety.
- Assist with barrier removal to achieve quality and patient safety strategies.

Facilitator: PMH Chief Quality and Patient Safety Officer

Suggested Members: Appropriate Corporate Senior Leadership, chairperson from each Regional Council, Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, Medical Staff Director, IT&S Director, Supply Chain, others.

Regional Quality and Patient Safety Steering Council Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the Local Boards/Quality and Patient Safety Committees
- Engages in identifying ongoing quality and patient safety performance improvement opportunities at the regional level
- Provides recommendations for the Corporate Quality and Patient Safety agenda and strategy, incorporating local input
- Provides recommendations to the Corporate Council concerning prioritization of quality and patient safety activities based

on regional and local needs and opportunities

- Assist with identification of metrics to be monitored on corporate dashboards.
- Provides oversight for execution of the Quality and Patient Safety agenda and strategic plan across the region
- Ensures follow-up on regional initiatives and programs
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety
- Assist with barrier removal to achieve quality and patient safety strategies

Regional Steering Council Facilitator: Regional VP of Quality

Suggested Members: Member of Local Board/Quality and Patient Safety Committees,Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, IT&S Director, Supply Chain,

Ad Hoc Members: Radiology, Lab, Medical Staff, others as appropriate to subject matter

Committees: Responsible for building the infrastructure and provide oversight for key quality and patient safety activities. Potential Committees may include Medication Safety, Clinical Safety Improvement, Infectious Disease Preparedness, Regulation and Accreditation, Clinical Excellence, others as needed.

Rapid Action Work Groups: Completes rapid work for quick process and outcome improvement as needed. Examples include Core Measure improvement, HAC prevention, HAI prevention, Clinical Excellence etc. The team is responsible for creating and initiating performance improvement programs to include project plan, key elements, tool kits etc. Teams have a limited life depending upon the work product and outcomes.

Process

High Reliability Organization: A high reliability organization is an organization able to continually manages their environment thoughtfully and assume a constant state of vigilance resulting in the fewest possible number of errors, despite operating in a high

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stress, high-risk environment. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations. These changes will be achieved through:

- Leadership's commitment to achieving zero patient harm
- A fully functional just culture of safety throughout the organization,
- Widespread deployment of highly effective process improvement tools (Chassin and Loeb, 2013).

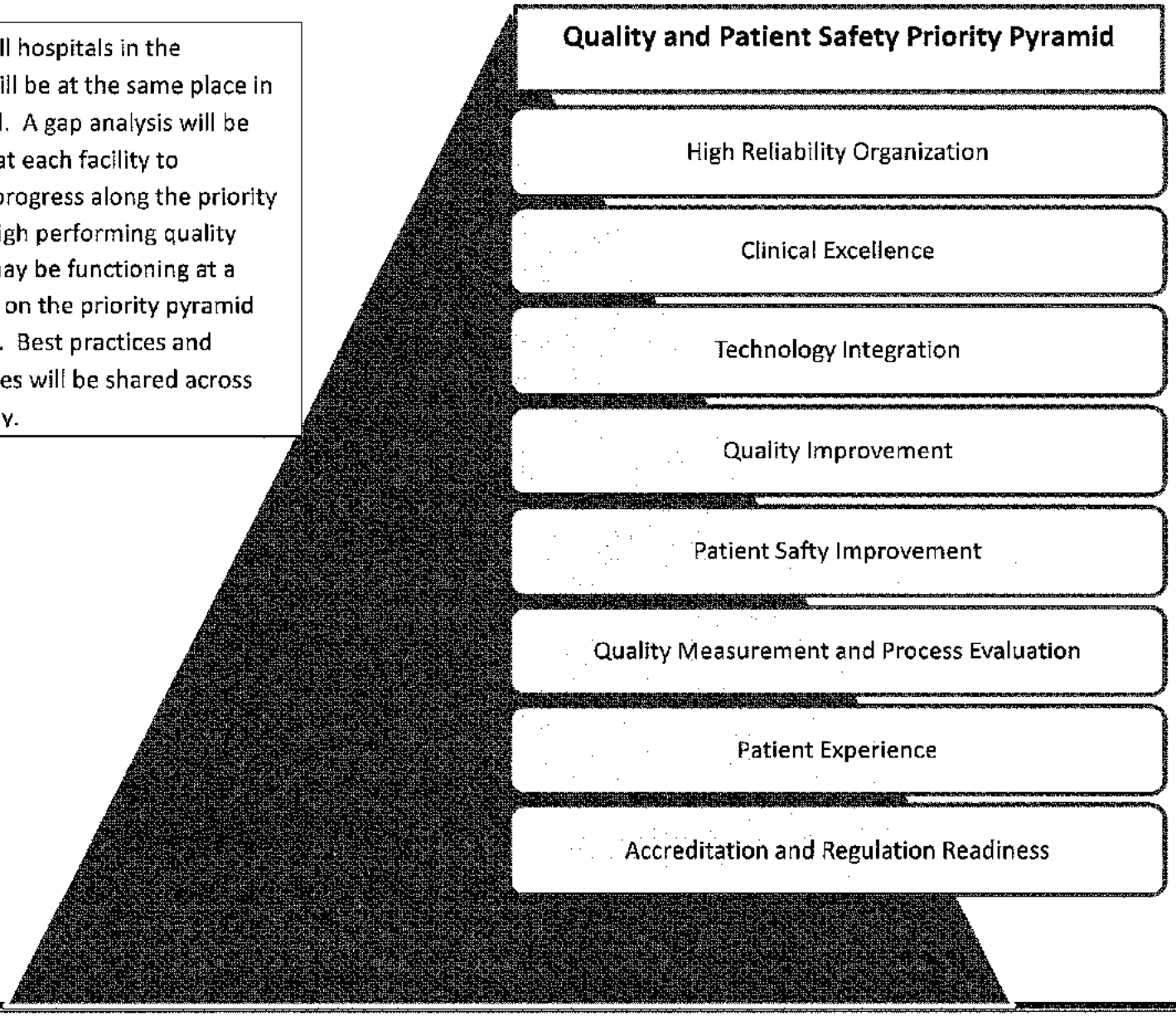
PMH is in the process of adopting high reliability behaviors and strategies to ensure a reduction in overall medical errors for our patients. High reliability organizations are built on a foundation of a just culture of safety. A key component of building this foundation is a robust incident reporting system to better understand trends, opportunities and strengths. We encourage that every unsafe condition, near miss/great save or harm event be reported and analyzed to identify opportunity for improvement to prevent future harm. We commit to maintaining transparency through sharing best practices and lessons learned across all of our hospitals. We further commit to build and share evidence-based, best practice, and performance improvement processes and tools kits to assist with supporting our quality and patient safety high reliability organization initiatives.

Strategies:

- **Accreditation and Regulation Readiness** – Implement an accreditation and regulation survey readiness team to ensure all hospitals are continually in compliance with the highest level of quality care and patient safety standards as defined by CMS, TJC, DNV, NCQA, and applicable State and local statutes and regulations. Provide subject matter expertise and tools to support the facilities in ongoing survey readiness.
- **Patient Experience** – Create and implement a patient experience program to ensure that each patient is treated with respect, compassion, consideration and is an integral partner in his or her plan of care.
- **Quality Measurement and Process Evaluation** – Build a standardized corporate quality and patient safety dashboard with national benchmarks. Institute monthly Quality and Patient Safety calls to review metrics, analysis and action plans to ensure ongoing improvement.

- **Patient Safety Improvement** – Create and implement a plan to move all hospitals towards a just culture of safety and accountability. Ensure quality and safe delivery of healthcare by defining and promoting consistent processes for identifying situations that may put patients or others at risk and acting to prevent or control those risks i.e. thorough and credible analysis of incidents of harm, near misses/great catches; FMEAs; ongoing learning through transparency, and implementation of patient safety tools such as **Quality Improvement** - Maximize pay-for-performance for quality performance and outcomes metrics including VBP, readmission reduction program, HAC/HAI reduction program, Medicare spending per beneficiary (MSPB), Meaningful Use etc.
- **Technology Integration** – Maximize available patient safety technologies including CPOE, health information technology, clinical decision support, bar coding and other technologies to enhance the quality and patient safety.
- **Clinical Excellence** – Improve mortality, complications, and length of stay through implementation of clinical excellence initiatives such as sepsis, stroke and STEMI management; effective blood utilization; ventilator management; and antibiotic stewardship.
- **High Reliability Organization** – Implement proven high reliability techniques and nationally recognized best practices to prevent harm and promote quality of care such as Red Rules (limited), SBAR (Situation, Background, Assessment and Recommendation), and STAR (Stop, Think, Act and Review).

Note: Not all hospitals in the Company will be at the same place in the pyramid. A gap analysis will be completed at each facility to determine progress along the priority pyramid. High performing quality programs may be functioning at a higher level on the priority pyramid than others. Best practices and performances will be shared across the company.



C1341

Outcomes

Corporate Quality and Patient Safety Dashboard

Quality, clinical and patient safety performance and outcomes will be measured via the newly created corporate Quality and Patient Safety Dashboard. Dashboards will be share across the company for the purpose of benchmarking and learning from other.

Hospital Quality and Patient Safety Call

Outliers will be addressed during the regularly scheduled hospital quality and patient safety calls. Best practices will be identified and shared with other hospitals in the company during these calls. The hospital will implement performance improvement activities to address the root cause and followed-up will occur during the next call. Once well established, the hospital call will occur at the regional level with a summary report forwarded to the corporate CQO.

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C1942

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Weaver, S. et al. (2013). Promoting a culture of safety as a patient safety strategy: A systematic review. Ann Intern Med. 158(5_Part_2), 369-374.

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, May 27, 2016 1:56 PM
To: Greer, Leslie; Olejarz, Barbara
Cc: Martone, Kim; Cotto, Carmen; Riggott, Kaila; Roberts, Karen
Subject: Fw: GWHN/Prospect/Late File Exhibits
Attachments: N5232653.PDF

Leslie,

Please add to the record.

Thank you,

Steve

From: Anne D. Peterson <APeterson@carmodylaw.com>
Sent: Friday, May 27, 2016 12:34:22 PM
To: Hawes, Gary W.; Lazarus, Steven; Hansted, Kevin
Cc: mmv@bvmlaw.com; Kathleen Gedney (kgg@bvmlaw.com); Ann H. Zucker
Subject: GWHN/Prospect/Late File Exhibits

Hi all - attached please find Late File Exhibits 2, 3, 4, 6, and 7 from the Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. hearing. Thank you for your consideration, and have a nice weekend.

Anne

Anne D. Peterson | Bio
Carmody Torrance Sandak & Hennessey LLP
195 Church Street | P.O. Box 1950
New Haven, CT 06509-1950
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Late File Exhibits 2, 3, 4, 6 and 7

Greater Waterbury Health Network, Inc.

Prospect Medical Holdings, Inc.

OHCA Docket Number 15-32017-486

Attorney General Docket Number 15-486-02

May 27, 2016

Late File Exhibit 2 – List of Grants That Will Pass to Waterbury Hospital Post-Closing

Late File Exhibit 2

Grants Awarded During FY 2015-2016 - For Profit Organization

Name	Funder	Grant Period	Total Award	Comment
Bioterrorism	CT Department of Public Health	07/01/15-06/30/16	$ 26,605.00	Five year contract through 06/30/17
H-1B Visa Grant	Northwest Regional Workforce Investment Board	04/02/12-06/30/16	$ 94,813.00	Four year contract through 06/30/16
Private Foundations-Summer Bridge	The Harold Leever Cancer Center	05/01/15-08/31/15	$ 5,000.00	Must request every year.
	Northwest Regional Workforce Investment Board	07/01/15-08/30/15	$ 8,610.21	Must apply every year.
	Gear Up Program	05/01/15-08/31/15	$ 2,800.00	Must request every year.
	Waterbury Department of Public Health	05/01/15-08/31/15	$ 2,000.00	Must apply every year.
	Waterbury Public Schools	05/01/15-08/31/15	$ 6,000.00	Must apply every year.
WHAP	CT Department of Public Health	07/01/15-06/30/16	$ 246,376.00	Three year contract through 06/30/16
	Malta House of Care Van	10/01/15-09/30/16	$ 19,560.00	MOU
	Saint Mary's Hospital	10/01/14-09/30/15	$ 13,684.00	Partner Shortfall Contribution
	Staywell Health Center	10/01/14-09/30/15	$ 6,842.00	Partner Shortfall Contribution
Clinical Trials	University of Connecticut	01/20/15-03/31/16	$ 34,684.00	Ended on 03/31/16
HIV Testing Initiative	CT Department of Public Health	01/01/16-12/31/16	$ 70,035.00	Four year contract through 12/31/16
Biomarkers	National Cancer Institute	08/01/15-03/31/16	$ 18,750.00	Contract through 03/31/16, applied for no-cost extension until 03/01/2017
Total			$ 555,759.21	

Late File Exhibit 3 – Update to Net Proceeds Analysis
(See Bates page 1419)

Late File Exhibit Number 3**

GWHN FILING TABLES

	Balance Sheet as of 4/31/2016 (Ownership Adjusted)	Pro Forma		Cash Accounts	Liquid	Restricted
		Retained by Surviving Entity	Purchased/ Assumed by Prospect			
Assets						
Current Assets:						
Cash and Cash Equivalents	$21,541,092	$21,541,092	$ -	$21,541,092	$19,358,904	$2,182,188
Short-term Investments	$1,561,149	$1,561,149	$ -	$1,561,149	$1,360,746	$200,403
Net Accounts Receivable	$31,231,555	$120,745	$31,110,810			
Accts Receivable - Other	$6,967,935	$3,036,237	$3,931,698			
Inventories	$3,382,956	$ -	$3,382,956			
Prepaid Insurance and Other Expenses	$2,990,897	$1,412,548	$1,578,349			
Due From Affiliates	$ (199,317)	$ (199,317)	$ -			
Total Current Assets	$67,476,267	$27,472,454	$40,003,813			
Noncurrent Assets Who Use Is Limited:						
CHEFA Bond Issue Cost	$276,491	$276,491	$ -			
Investments	$26,133,525	$26,133,525	$ -	$26,133,525	$14,454,996	$11,678,529
Board Designated Funds	$ -	$ -	$ -	$ -	$ -	$ -
Loans and Other Receivables	$358,967	$358,967	$ -			
Funds Held in Trust by Others	$44,360,163	$44,360,163	$ -	$44,360,163	$ -	$44,360,163
Goodwill	$1,813,567	$ -	$1,813,567	$93,595,930	$35,174,646	$58,421,284
Net PP&E	$32,859,094	$2,017,680	$30,841,415			
Total Assets	**$173,278,075**	**$100,619,280**	**$72,658,795**			
Liabilities						
Current Liabilities						
Accounts Payable and Accrued Expenses	$(24,590,513.26)	$(2,845,611)	$(21,744,901.97)			
Current Portion of Accrued Pension Liablility	$(3,867,000)	$ -	$(3,867,000)			
Current Portion of Long Term Debt	$(1,868,842)	$(730,171)	$(1,138,671)			
Due to Third-Party Payors	$(9,892,308)	$(9,892,308)	$ -			
Total Current Liabilities	$(40,218,663)	$(13,468,090)	$(26,750,573)			
Long-Term Debt	$(27,238,731)	$(24,392,518)	$(2,846,213)			
Other Long-Term Liabilities:						
Workers Compensation	$(12,108,687)	$(12,108,687)	$ -			
Pension	$(8,496,507)	$ -	$(8,496,507)			
Malpractice	$(1,792,061)	$ -	$(1,792,061)			
Asbestos Abatement	$(2,898,529)	$ -	$(2,898,529)			
Other Long-Term Liabilities	$(2,338,428)	$(2,338,428)	$ -			
Total Other Liabilities	$(54,872,943)	$(38,839,633)	$(16,033,310)			
Total Liabilities	**$(95,091,606)**	**$(52,307,723)**	**$(42,783,883)**			

Net Assets	$78,186,469	$48,311,557	$29,874,912
Net Balance Sheet Items	**$173,278,075**	**$100,619,280**	**$72,658,795**

	4/30/2016
Proceeds Calculation	
Proceeds	
Enterprise Value	$25,000,000
Working Capital Adjustment	18,258,911
Total Gross Proceeds	$43,258,911
PM Assumed Liabilities	
Asbestos Abatement	$(2,898,529)
Nurses Pension	$(27,000,000)
Hospital Cash Balance Plan	$(12,363,507)
Total Assumed Liabilities	$(42,262,036)
Net Proceeds	$996,875
Unrestricted Cash	$35,174,646
Total Unrestricted Cash and Net Proceeds	$36,171,521
Cash Needs at Closing	
Estimated Transaction Costs	$(1,450,000)
Bank Debt	$(23,783,297)
Debt Swap	$(1,851,544)
Total Cash Needs at Closing	$(27,084,841)
Net Cash Post Closing Liabilities & Expenses	$9,086,680

** Please note that all figures in this Exhibit are current through April 30, 2016, with the exception of the Children's Center, which is current through March 31, 2016

Late File Exhibit 4 – All Amendments to LOI and Proposed Changes to APA

To date, there are no executed amendments to the LOI that have not been previously submitted. The parties will provide amendments to the LOI and an updated Asset Purchase Agreement upon execution by both parties.

Late File Exhibit 6 – Updated Value of Charitable Funds

Late File Exhibit 6

Fund (3/31/2016)	Amount	Restricted	Unrestricted	Charity Care	Nursing Education	Behavioral Health	Hospitalized Children	Chase Clinic	Scholarship Assistance	Breast Cancer Research	Equipment	Lab Conferences	Pediatrics Unit	
Charles F Booker	$163,611	-	$163,611											
Clara A Forester (Robert)	$77,834	-	$77,834											
Karl and Margaret Hallden	$92,260	-	$92,260											
George R. Lamb	$267,050	-	$267,050											
Subtotal	**$600,756**	0	**$600,756**											
Hattie/Harriet Schlegel Anderson	$111,965	$111,965	0			111,965								
At Risk Kids	949	949	0				949							
Theodore Bevans	8,761	8,761	0					8,761						
Edith M. Chase (Memorial Despens)	742,151	742,151	0						742,151					
Mildred Crozier	289,004	289,004	0							289,004				
Marguerite B. Fulling	78,984	78,984	0								78,984			
Grad Nurse	7,360	7,360	0			7,360								
Margery K. Hayden (Elizabeth)	32,281	32,281	0		32,281									
Merritt Heminway	226,452	226,452	0		226,452									
Junior League Fund (Special Med)	2,007	2,007	0		2,007									
Sarann B. Kazanjian (Memorial)	66,168	66,168	0									66,168		
Sarann B. Kazanjian (Ed Seminar)	45,220	45,220	0			45,220								
Scovill-Kingsbury	230,039	230,039	0		230,039									
LJ Mayo	13,396	13,396	0			13,396								
Mary L. Meigs	1,135,330	1,135,330	0		1,135,330									
Dr. M.H. Merriman	5,489	5,489	0										5,489	
Mary Kingsbury Bull Fund	20,982	20,982	0											20,982

Fund (3/31/2016)	Amount	Restricted	Unrestricted	Charity Care	Nursing Education	Behavioral Health	Hospitalized Children	Chase Clinic	Scholarship Assistance	Breast Cancer Research	Equipment	Lab Conferences	Pediatrics Unit	
Edith F. Poole	-	-	0		-									
Flora F. Page&George W Smith (Curtis Hurlbut)	182,028	182,028	0		182,028									
Ruth Sperry (Mark)	180,286	180,286	0		180,286									
Dwight Terry&Martha Terry	629,021	629,021	0		629,021									
Olive Rogers Warner	-	-	0		-									
Subtotal	**$4,007,871**	**$4,007,871**	**$ -**		$2,617,443	$177,942	$949	$8,761	$742,151	$289,004	$78,984	$66,168	$5,489	$20,982
Funds Held in Trust														
Harriet/Hattie Anderson	$81,916	$81,916	0		81,916									
Edith Blakesley Fund	-	-	0											
Almon B. Dayton	107,775	0	107,775											
Natalie M. Dodd	0	0	0											
John Elton #2	286,568	0	286,568											
J Lincoln Fenn	0	0	0											
I. Kent Fulton	6,490,643	0	6,490,643											
Donald F. Gibson	0	0	0											
Charles Hellman	9,999,451	0	9,999,451											
Rhoda M. Hellman	5,099,419	0	5,099,419											
Abbie C. Hopkins	5,623,207	5,623,207	0		5,623,207									
Frank Keeling	3,136,709	0	3,136,709											
Jacob Keeling	2,416,113	0	2,416,113											
Harriet Kirk	470,834	0	470,834											
Henry H. Peck	7,979,013	0	7,979,013											
Edith F. Poole	138,493	0	138,493											
W. Easton Smith	121,447	0	121,447											
Wilma A. Snowden	0	0	0											
Kenneth J. Stoughton	0	0	0											
Oscar L. Warner	2,341,724	2,341,724	0		2,341,724									
Subtotal	**$44,293,313**	**$8,046,848**	**$36,246,465**		$8,046,848									

Fund (3/31/2016)	Amount	Restricted	Unrestricted	Charity Care	Nursing Education	Behavioral Health	Hospitalized Children	Chase Clinic	Scholarship Assistance	Breast Cancer Research	Equipment	Lab Conferences	Pediatrics Unit		
Miscellaneous															
Thomas P Crean	$ -	0	$ -												
Gift Annuity	127,798	0													
Stephen J. Pecka	-	0	-												
Pooled Income Fund	-	0	-												
Subtotal	**$127,798**	0	$ -												
Permanent Bed Funds	$4,801,340	$4,801,340	0		$4,801,340										
General Endowment	$ -	0	$ -												
Grand Total	$53,831,077	$16,856,058	$36,847,221		$15,465,630	$177,942	$949	$8,761	$742,151	$289,004	$78,984	$66,168	$5,489	$20,982	$16,856,058

01854

Late File Exhibit 7 – List of Funds/Grants That Will Not Pass to Waterbury Hospital Post-Closing

Late File Exhibit Number 7

01856

Grants Awarded During FY 2015-2016 - Non Profit Organization

Name	Funder	Grant Period	Total Award	Comment
Parent Trust Grant	State Education Resource Center	09/01/15-06/30/16	$ 36,492.00	Must apply every year. Reapply around July/Aug. 2016
Ryan White Part C	Health Resources & Services Administration	04/01/16-03/31/17	$ 426,543.00	Must apply every two years. Must reapply around September/October 2016.
Ryan White Part A	City of New Haven	04/01/15-03/31/16	$ 995,644.00	No longer Lead Agency for the region due to transition to for-profit. Now a subcontrator under Staywell Health Center. (1 year subcontract, renewed every year)
Private Foundations-Summer Bridge	ION Bank Foundation	05/01/15-08/31/15	$ 3,000.00	Must apply every year around February. (Did not apply in FY 16)
	George A. & Grace L. Long Foundation	03/01/15-08/31/15	$ 3,026.00	Must apply every year around January. (Did not apply in FY 16)
WHAP	Connecticut Community Foundation	01/01/15-12/31/15	$ 25,000.00	Must apply every year around January. (Did not apply in FY 16)
	New Opportunities, Inc.	10/01/14-09/30/15	$ 51,034.00	MOU through October 2016
340B Ryan White Part C	Health Resources & Services Administration	Ongoing	$ 1,356,942.99	Eligible through RW Part C grant, 340B Contract with Mail Order Pharmacy (revenue goes back into ID Clinic)
Total			**$ 2,909,765.99**	

Fund (3/31/2016)	Amount	Restricted	Unrestricted		Charity Care	Nursing Education	Behavioral Health	Hospitalized Children	Chase Clinic	Scholarship Assistance	Breast Cancer Research	Equipment	Lab Conferences	Pediatrics Unit
Charles F Booker	$163,611	-	$163,611											
Clara A Forester (Robert)	77,834	-	$77,834											
Karl and Margaret Hallden	92,260	-	$92,260											
George R. Lamb	267,050	-	$267,050											
Subtotal	**$600,756**	0	**$600,756**											
Hattie/Harriet Schlegel Anderson	$111,965	111,965	0	Y		111,965								
At Risk Kids	949	949	0	Y			949							
Theodore Bevans	8,761	8,761	0	Y				8,761						
Edith M. Chase (Memorial Despens)	742,151	742,151	0	Y					742,151					
Mildred Crozier	289,004	289,004	0	Y						289,004				
Marguerite B. Fulling	78,984	78,984	0	Y							78,984			
Grad Nurse	7,360	7,360	0	Y		7,360								
Margery K. Hayden (Elizabeth)	32,281	32,281	0	N	32,281									
Merritt Heminway	226,452	226,452	0	N	226,452									
Junior League Fund (Special Med)	2,007	2,007	0	N	2,007									
Sarann B. Kazanjian (Memorial)	66,168	66,168	0	Y								66,168		
Sarann B. Kazanjian (Ed Seminar)	45,220	45,220	0	Y		45,220								
Scovill-Kingsbury	230,039	230,039	0	N	230,039									
LJ Mayo	13,396	13,396	0	Y		13,396								
Mary L. Meigs	1,135,330	1,135,330	0	N	1,135,330									
Dr. M.H. Merriman	5,489	5,489	0	N									5,489	
Mary Kingsbury Bull Fund	20,982	20,982	0	N										20,982
Edith F. Poole	-	-	0	N	-									
Flora F. Page&George W Smith (Curtis Hurlbut)	182,028	182,028	0	N	182,028									
Ruth Sperry (Mark)	180,286	180,286	0	N	180,286									
Dwight Terry&Martha Terry	629,021	629,021	0	N	629,021									
Olive Rogers Warner	-	-	0		-									
Subtotal	**$4,007,871**	**$4,007,871**	**$ -**		$2,617,443	$177,942	$949	$8,761	$742,151	$289,004	$78,984	$66,168	$5,489	20,982

Fund (3/31/2016)	Amount	Restricted	Unrestricted		Charity Care	Nursing Education	Behavioral Health	Hospitalized Children	Chase Clinic	Scholarship Assistance	Breast Cancer Research	Equipment	Lab Conferences	Pediatrics Unit
Funds Held in Trust														
Harriet/Hattie Anderson	$81,916	$81,916	0	N	81,916									
Edith Blakesley Fund	-	-	0		-									
Almon B. Dayton	107,775	0	107,775											
Natalie M. Dodd	0	0	0											
John Elton #2	286,568	0	286,568											
J Lincoln Fenn	0	0	0											
I. Kent Fulton	6,490,643	0	6,490,643											
Donald F. Gibson	0	0	0											
Charles Hellman	9,999,451	0	9,999,451											
Rhoda M. Hellman	5,099,419	0	5,099,419											
Abbie C. Hopkins	5,623,207	5,623,207	0	N	5,623,207									
Frank Keeling	3,136,709	0	3,136,709											
Jacob Keeling	2,416,113	0	2,416,113											
Harriet Kirk	470,834	0	470,834											
Henry H. Peck	7,979,013	0	7,979,013											
Edith F. Poole	138,493	0	138,493											
W. Easton Smith	121,447	0	121,447											
Wilma A. Snowden	0	0	0											
Kenneth J. Stoughton	0	0	0	N										
Oscar L. Warner	2,341,724	2,341,724	0	N	2,341,724									
Subtotal	**$44,293,313**	**$8,046,848**	**$36,246,465**		$8,046,848									
Miscellaneous														
Thomas P Crean	$ -	0	$ -											
Gift Annuity	127,798	0												
Stephen J. Pecka	-	0	-											
Pooled Income Fund	-	0	-											
Subtotal	**$127,798**	0	$ -											

01858

Fund (3/31/2016)	Amount	Restricted	Unrestricted		Charity Care	Nursing Education	Behavioral Health	Hospitalized Children	Chase Clinic	Scholarship Assistance	Breast Cancer Research	Equipment	Lab Conferences	Pediatrics Unit	
Permanent Bed Funds	$4,801,340	$4,801,340	0	N	4,801,340										
General Endowment	$ -	0	$ -												
Grand Total	$53,831,077	$16,856,058	$36,847,221		$15,465,630	$177,942	$949	$8,761	$742,151	$289,004	$78,984	$66,168	$5,489	$ 20,982	$16,856,058
Y = $$$ to Foundation		1,363,958													
N = $$$ Not to Foundation		15,492,100													
Total		16,856,058													

01859

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Friday, June 03, 2016 12:03 PM
To: Lazarus, Steven
Cc: Ann H. Zucker; Cotto, Carmen; Greer, Leslie; Jennifer O'Donnell; Michele Volpe
Subject: RE: Follow Up on the Late Files regarding DN: 15-32017-486
Attachments: GWHN PMH Late Files 1 and 5 (5.24.16).pdf

All:

Pursuant to Michele's email below, attached please find Late Files 1 and 5 that were originally sent May 24, 2016.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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From: Michele Volpe
Sent: Friday, June 03, 2016 12:01 PM
To: Lazarus, Steven <Steven.Lazarus@ct.gov>
Cc: Ann H. Zucker <AZucker@carmodylaw.com>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Kathleen Gedney <kgg@bvmlaw.com>; Jennifer O'Donnell <jlo@bvmlaw.com>
Subject: Re: Follow Up on the Late Files regarding DN: 15-32017-486

Steve we will resend. Thanks

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On Jun 3, 2016, at 11:58 AM, Lazarus, Steven <Steven.Lazarus@ct.gov> wrote:

Hi Michele,

We verified and the email sent with the Late Files only mentions and includes Exhibits 2 onwards, was Exhibit 1 sent separately? We may have missed it.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053
<image001.jpg>

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, June 03, 2016 11:48 AM
To: Lazarus, Steven
Cc: Ann H. Zucker; Cotto, Carmen; Greer, Leslie; Kathleen Gedney; Jennifer O'Donnell
Subject: Re: Follow Up on the Late Files regarding DN: 15-32017-486

Ok great thank you. We can easily resend if that is less time consuming for you. Let me know.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On Jun 3, 2016, at 11:46 AM, Lazarus, Steven <Steven.Lazarus@ct.gov> wrote:

> Michele,
>
> Let me have Leslie check the paper file to make sure before we move forward. I'll get right back to you.
>
> Steve
>
> *Steven W. Lazarus*
> Associate Health Care Analyst
> Division of Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue

Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053
<image001.jpg>

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, June 03, 2016 11:45 AM
To: Lazarus, Steven
Cc: Ann H. Zucker; Cotto, Carmen; Greer, Leslie; Kathleen Gedney; Jennifer O'Donnell
Subject: Re: Follow Up on the Late Files regarding DN: 15-32017-486

Hi Steve
A late file response for question 1 was submitted and answered the question presented. Did you receive it? We can resend? Was it deficient in some respect?Please provide clarity on your request. Thank you.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On Jun 3, 2016, at 11:08 AM, Lazarus, Steven <Steven.Lazarus@ct.gov> wrote:

> Good Morning Michele and Ann,
>
> Can you please provide me an update and a timeline about the missing late file (see below in yellow highlight) from the late files provided for GWHN/PMH proposal last week?

1	Report Re: How PMH Will Finance All Transactions, ECHN's, GWHN's and CKHS' (list total cost, total cash needed at closing, funding source and dollar amounts available to cover the cost and cash needed at closing)

> Thank you,
>
> Steve
>
> *Steven W. Lazarus*
> Associate Health Care Analyst
> Division of Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue

Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

Late Files 1 and 5

Greater Waterbury Health Network, Inc.
Prospect Medical Holdings, Inc.

OHCA Docket Number 15-31217-486
Attorney General Docket Number 15-486-02

May 24, 2016

Late File 1 - Report Re: How PMH Will Finance All Transactions - ECHN's, GWHN's and CKHS' (list total cost, total cash needed at closing, funding source and dollar amounts available to cover the cost and cash needed at closing)

Prospect Medical Holdings *5/10/2016*

Late File Submission: Inquiry as to funding sources for acquisitions

Sources		**Uses**	
		Projected Cash at Close	
Financing (June 2016)	$ 155,032	Crozer Keystone Health System	$ 155,032
Cash from Existing Operations	28,000	Eastern Connecticut Health Network	28,000
Cash from Existing Operations	-	Greater Waterbury Hospital Network	-
	$ 183,032		$ 183,032

Footnote

Prospect Medical Holdings projected cash at close 7/31/16	+	*80,000,000*
Full Revolver Availability (balance to be paid with June '16 financing)		*60,000,000*

CT8631

Late File 5 - Updated PMH Quality Organizational Chart

Introduction

Philosophy: To ensure that our patients receive the right care, at the right time, in the right setting, with efficiency and compassion.

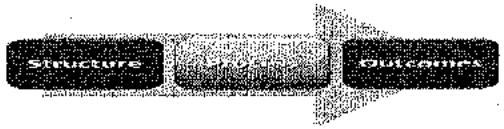
Mission: Above all, we are committed to quality in all aspects of healthcare delivery, including:

- Striving for the best possible patient outcomes
- Maintaining the highest standards of patient safety
- Acting with integrity at all times
- Promoting open communication
- Collaborating to better serve the healthcare needs of our communities

Purpose: The PMH Quality and Patient Safety Program will focus on continuous enhancement of quality and safety for all we serve. Every employee plays a crucial role in ensuring patient, visitor and employee safety. We will work to reconnect quality and patient safety to clinical care thereby promoting high quality, safe, effective and efficient care. Additionally, the program will strive to build a just culture of safety by implementing strategies to reduce medical errors. Reducing risk and ensuring safety requires increased attention to systems that prevent and mitigate errors. The corporate quality and patient safety team will work with hospital to provide appropriate solutions to ensure best practices, resulting in quality patient care and service.

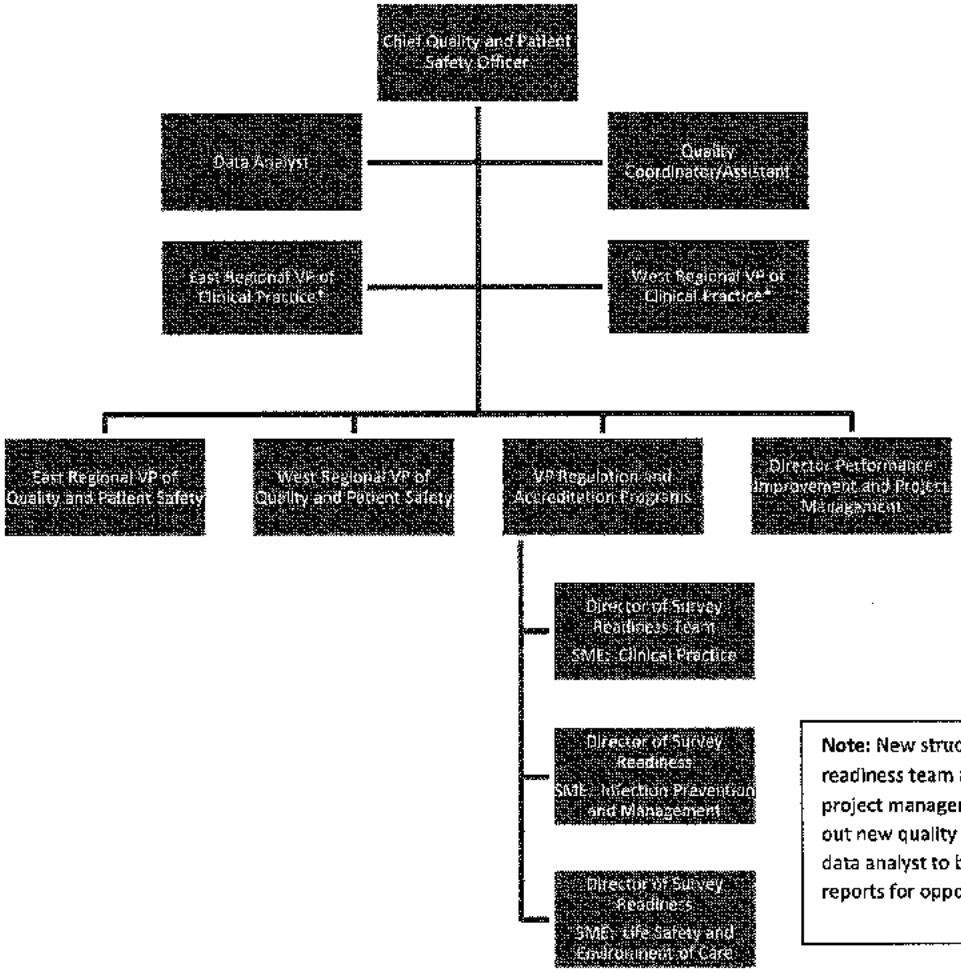
Goal: Build corporate and regional structures and processes necessary to become a high reliability organization promoting patient-focused, high quality, safe, compassionate, efficient, and effective care.

Model: We will achieve our mission and purpose through building and sustaining a robust quality and patient safety program at all levels of the organization. The key elements of this program will include: innovation, service, education, transparency, and patient partnerships. We will be using the Donabedian Quality of Care Model as our framework for building the program. Our initial focus will be on creating the corporate structure to enhance our ability to build processes and achieve outcomes.



C18833

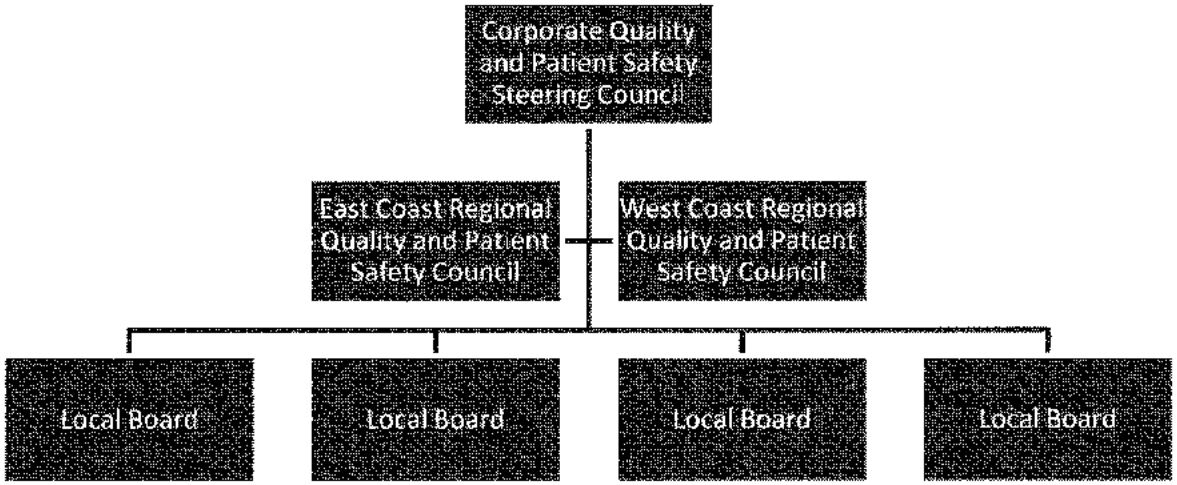
Corporate and Regional Quality Performance Improvement and Patient Safety Structure



Note: New structure will include a mobile survey readiness team and a performance improvement project manager to assist with designing and rolling out new quality and patient safety initiatives and a data analyst to build and interpret standardized reports for opportunities.

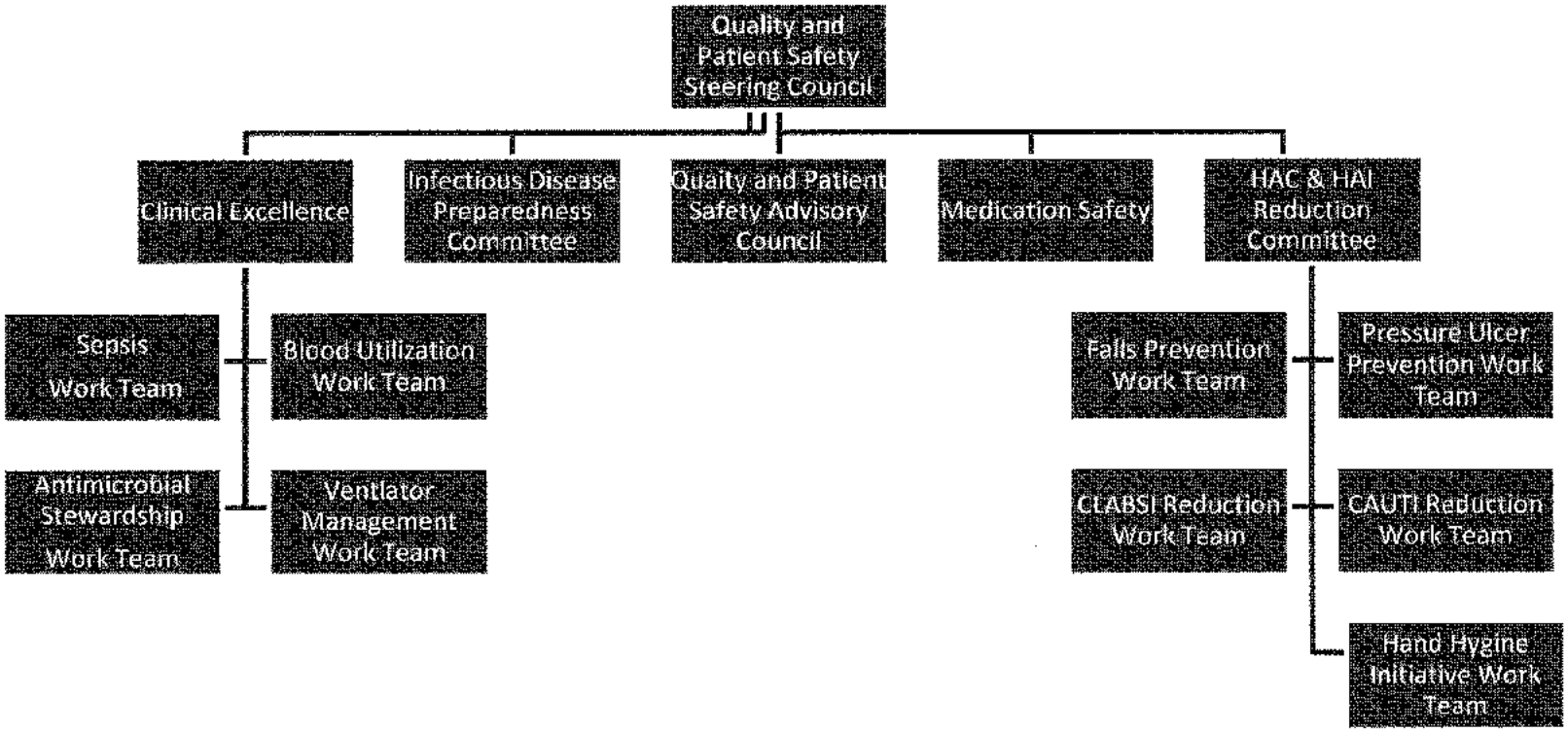
C1834

Quality and Patient Safety Communication and Reporting Structure



Note: Local Board will report up through the appropriate Regional Council to the Corporate Council with final reporting to the Corporate Board of Directors.

Corporate Quality and Patient Safety Steering Council



Note: Suggestions for potential committees and work groups under committees. These may change based on the finalized Quality and Patient Safety agenda and strategic plan. Committees and work groups may be added, deleted or changed based on organizational needs and priorities.

Corporate Quality and Patient Safety Steering Council Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the Regional Councils
- Assists with the development of the Corporate Quality and Patient Safety agenda and strategy, incorporating regional and local input
- Provides oversight for execution of the Quality and Patient Safety agenda and strategic plan across the Company
- Prioritizes Quality and Patient Safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from chartered committees and work teams for implementation across the company
- Engages in identifying ongoing quality and patient safety performance improvement opportunities
- Ensures follow-up on regional initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety.
- Assist with barrier removal to achieve quality and patient safety strategies.

Facilitator: PMH Chief Quality and Patient Safety Officer

Suggested Members: Appropriate Corporate Senior Leadership, chairperson from each Regional Council, Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, Medical Staff Director, IT&S Director, Supply Chain, others.

Regional Quality and Patient Safety Steering Council Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the Local Boards/Quality and Patient Safety Committees
- Engages in identifying ongoing quality and patient safety performance improvement opportunities at the regional level
- Provides recommendations for the Corporate Quality and Patient Safety agenda and strategy, incorporating local input
- Provides recommendations to the Corporate Council concerning prioritization of quality and patient safety activities based

on regional and local needs and opportunities

- Assist with identification of metrics to be monitored on corporate dashboards.
- Provides oversight for execution of the Quality and Patient Safety agenda and strategic plan across the region
- Ensures follow-up on regional initiatives and programs
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety
- Assist with barrier removal to achieve quality and patient safety strategies

Regional Steering Council Facilitator: Regional VP of Quality

Suggested Members: Member of Local Board/Quality and Patient Safety Committees,Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, IT&S Director, Supply Chain,

Ad Hoc Members: Radiology, Lab, Medical Staff, others as appropriate to subject matter

Committees: Responsible for building the infrastructure and provide oversight for key quality and patient safety activities. Potential Committees may include Medication Safety, Clinical Safety Improvement, Infectious Disease Preparedness, Regulation and Accreditation, Clinical Excellence, others as needed.

Rapid Action Work Groups: Completes rapid work for quick process and outcome improvement as needed. Examples include Core Measure improvement, HAC prevention, HAI prevention, Clinical Excellence etc. The team is responsible for creating and initiating performance improvement programs to include project plan, key elements, tool kits etc. Teams have a limited life depending upon the work product and outcomes.

Process

High Reliability Organization: A high reliability organization is an organization able to continually manages their environment thoughtfully and assume a constant state of vigilance resulting in the fewest possible number of errors, despite operating in a high

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stress, high-risk environment. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations. These changes will be achieved through:

- Leadership's commitment to achieving zero patient harm
- A fully functional just culture of safety throughout the organization,
- Widespread deployment of highly effective process improvement tools (Chassin and Loeb, 2013).

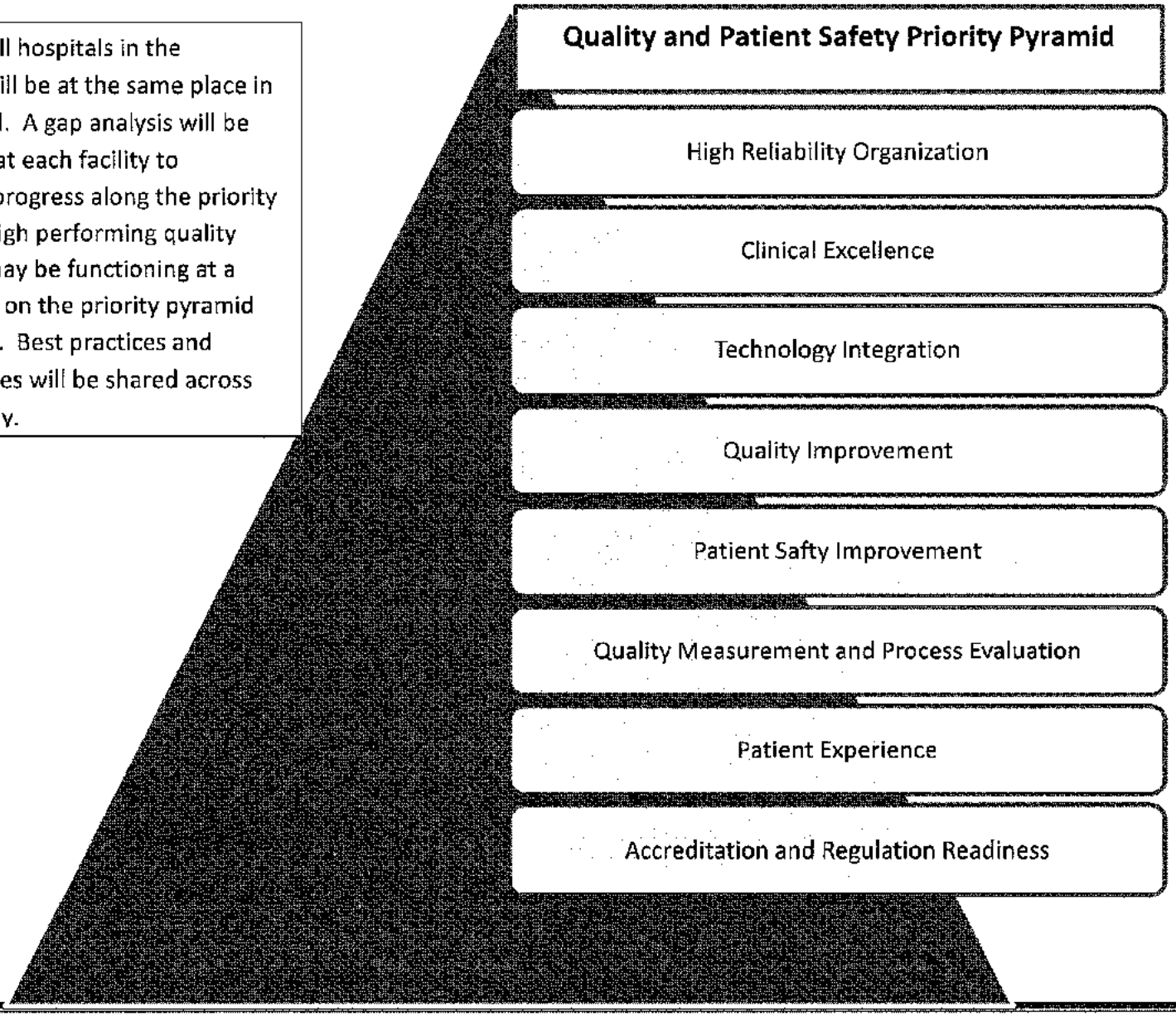
PMH is in the process of adopting high reliability behaviors and strategies to ensure a reduction in overall medical errors for our patients. High reliability organizations are built on a foundation of a just culture of safety. A key component of building this foundation is a robust incident reporting system to better understand trends, opportunities and strengths. We encourage that every unsafe condition, near miss/great save or harm event be reported and analyzed to identify opportunity for improvement to prevent future harm. We commit to maintaining transparency through sharing best practices and lessons learned across all of our hospitals. We further commit to build and share evidence-based, best practice, and performance improvement processes and tools kits to assist with supporting our quality and patient safety high reliability organization initiatives.

Strategies:

- **Accreditation and Regulation Readiness** – Implement an accreditation and regulation survey readiness team to ensure all hospitals are continually in compliance with the highest level of quality care and patient safety standards as defined by CMS, TJC, DNV, NCQA, and applicable State and local statutes and regulations. Provide subject matter expertise and tools to support the facilities in ongoing survey readiness.
- **Patient Experience** – Create and implement a patient experience program to ensure that each patient is treated with respect, compassion, consideration and is an integral partner in his or her plan of care.
- **Quality Measurement and Process Evaluation** – Build a standardized corporate quality and patient safety dashboard with national benchmarks. Institute monthly Quality and Patient Safety calls to review metrics, analysis and action plans to ensure ongoing improvement.

- **Patient Safety Improvement** – Create and implement a plan to move all hospitals towards a just culture of safety and accountability. Ensure quality and safe delivery of healthcare by defining and promoting consistent processes for identifying situations that may put patients or others at risk and acting to prevent or control those risks i.e. thorough and credible analysis of incidents of harm, near misses/great catches; FMEAs; ongoing learning through transparency, and implementation of patient safety tools such as **Quality Improvement** - Maximize pay-for-performance for quality performance and outcomes metrics including VBP, readmission reduction program, HAC/HAI reduction program, Medicare spending per beneficiary (MSPB), Meaningful Use etc.
- **Technology Integration** – Maximize available patient safety technologies including CPOE, health information technology, clinical decision support, bar coding and other technologies to enhance the quality and patient safety.
- **Clinical Excellence** – Improve mortality, complications, and length of stay through implementation of clinical excellence initiatives such as sepsis, stroke and STEMI management; effective blood utilization; ventilator management; and antibiotic stewardship.
- **High Reliability Organization** – Implement proven high reliability techniques and nationally recognized best practices to prevent harm and promote quality of care such as Red Rules (limited), SBAR (Situation, Background, Assessment and Recommendation), and STAR (Stop, Think, Act and Review).

Note: Not all hospitals in the Company will be at the same place in the pyramid. A gap analysis will be completed at each facility to determine progress along the priority pyramid. High performing quality programs may be functioning at a higher level on the priority pyramid than others. Best practices and performances will be shared across the company.



C1341

Outcomes

Corporate Quality and Patient Safety Dashboard

Quality, clinical and patient safety performance and outcomes will be measured via the newly created corporate Quality and Patient Safety Dashboard. Dashboards will be share across the company for the purpose of benchmarking and learning from other.

Hospital Quality and Patient Safety Call

Outliers will be addressed during the regularly scheduled hospital quality and patient safety calls. Best practices will be identified and shared with other hospitals in the company during these calls. The hospital will implement performance improvement activities to address the root cause and followed-up will occur during the next call. Once well established, the hospital call will occur at the regional level with a summary report forwarded to the corporate CQO.

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C1942

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Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicants:	Greater Waterbury Health Network, Inc. 64 Robbins Street Waterbury, CT 06708 Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard Suite 400 Los Angeles, CA 90025
Docket Number:	15-32017-486
Project Title:	Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.

Procedural History: On July 16, 2015, the Applicants filed with the Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG") the Certificate of Need ("CON") Determination Letter proposing the transfer of assets of Greater Waterbury Health Network, Inc. and affiliates ("GWHN") to Prospect Medical Holdings, Inc. ("PMH"). The Applicants filed the application for the proposal on October 28, 2015. On March 4, 2016, OHCA and the OAG deemed the application complete.

On April 8, 2016, OHCA and the OAG notified the Applicants of the date, time and place of the public hearing. A notice to the public announcing the hearing was published in the *Republican American*. Thereafter, pursuant to Conn. Gen. Stat. §19a-639a and §19a-486, a public hearing regarding this application was held on May 3, 2016, jointly by OHCA and the OAG.

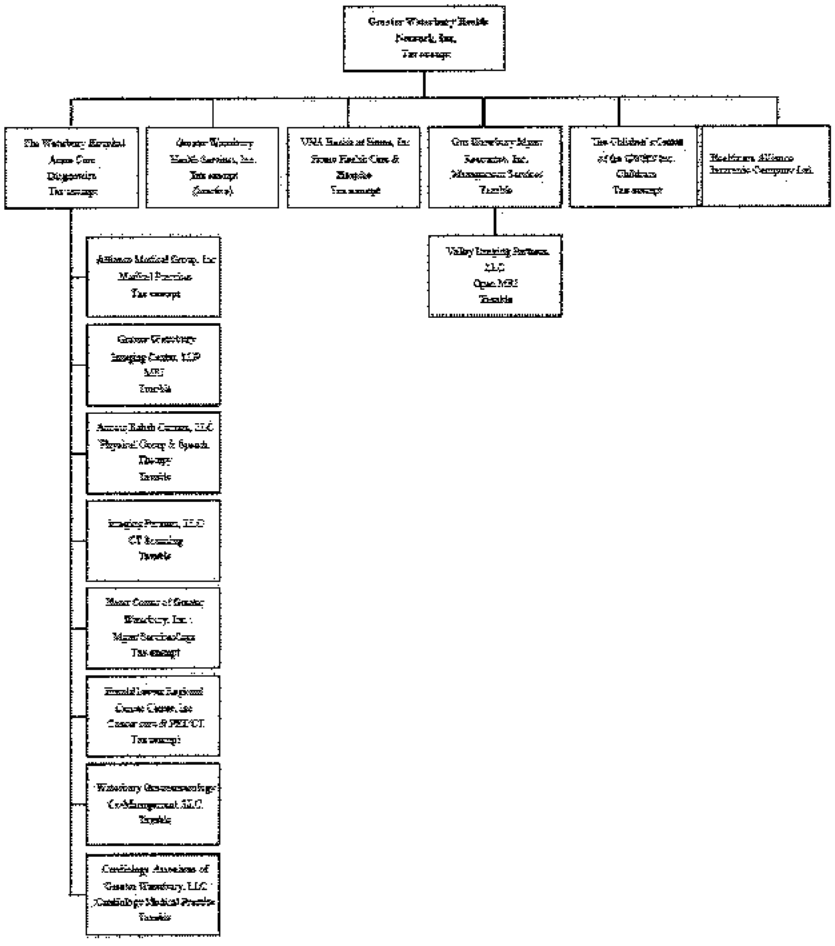
Attorney Kevin T. Hansted has been designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedures Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. §19a-639a(f).

The Hearing Officer heard testimony from witnesses for the Applicants and, in rendering this decision, considered the entire record of the proceeding.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc. v. S & H Computer Systems, Inc.*, 605 F. Supp. 816 (Md. Tenn. 1985).

Findings of Fact

1. GWHN is a non-stock, 501(c)(3) corporation that is the parent company to The Waterbury Hospital ("Hospital"), an acute care teaching hospital with 357 licensed beds plus 36 bassinets located in Waterbury, Connecticut. GWHN also holds interests in other entities, joint ventures, and affiliates. The chart below describes GWHN's current organizational structure:



Ex. E, p. 13

2. In addition to the Hospital, which is wholly owned by GWHN, GWHN is also an equity holder in the following entities: Healthcare Alliance Insurance Company, Ltd. ("HAIC," of which GWHN is a 50% owner), Greater Waterbury Health Services, Inc. ("GWHS," which is wholly-owned by GWHN), VNA Health at Home, Inc. (wholly-owned by GWHN), Greater Waterbury Management Resources, Inc. (wholly-owned by GWHN;

this company also has a 49% ownership in Valley Imaging, LLC), and Children's Center of Greater Waterbury Health Network, Inc. ("CCGWHN," which is wholly-owned by GWHN). Ex. E, pp. 15-16

3. The Hospital has ownership interests in the following entities: Alliance Medical Group, Inc. (wholly-owned by the Hospital), Greater Waterbury Imaging Center Limited Partnership (64% owned by the Hospital), Access Rehab Centers LLC (65% owned by the Hospital), Imaging Partners, LLC (85% owned by the Hospital), Waterbury Gastroenterological Co-Management Company, LLC (the Hospital is the sole Class H Member and has certain management rights), and Cardiology Associates of Greater Waterbury, LLC (wholly-owned by the Hospital). Ex. E, pp. 15-17

4. Additionally, the Hospital is a corporate member of two not-for-profit joint ventures with Saint Mary's Hospital ("SMH"): the Harold Leever Regional Cancer Center, Inc. and the Heart Center of Greater Waterbury, Inc. Ex. E, p. 17

5. The Hospital is GWHN's primary asset. It is a "safety net" hospital, treating a large number of Medicare, Medicaid and uninsured patients. Discharges for these three payers represent approximately 80% of the total patient days and 75.6% of emergency room outpatient visits. Ex. E, pp. 13, 15-16

6. The Hospital serves the following towns: Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury (the "Service Area"). Ex. E, p. 51

7. The Hospital has experienced consecutive years of losses due to poor economic conditions in the Service Area, declining government and commercial reimbursement, the increasing complexity of health care treatment, and national health care reform. Additionally the recession in 2008 led to GWHN defaulting on its bond covenants in 2009. In 2010, a consulting firm, Kaufman Hall, identified over $50 million in capital improvements required over five years to keep the Hospital operational. Ex. E, pp. 22-24, 333-434; Ex. R, Prefiled Testimony of Carl Contadini, Chairman of the Board, GWHN, p. 1509

8. In 2010, the Executive Committee of the GWHN Board of Directors (the "Board") recommended that the Hospital seek a capital partner and a task force was formed (the "Task Force"). Ex. E, p. 24

9. In 2011, the GWHN Board voted to authorize the negotiation of an agreement with LHP Hospital Group ("LHP") and SMH, but LHP ultimately terminated the proposed venture, citing the costs of building a replacement hospital and issues related to the Ethical and Religious Directives for Catholic Health Care Services. Ex. E, pp. 24-25

10. On September 4, 2012, the Board authorized the Task Force to pursue other opportunities, ultimately leading to the submission of proposals by Vanguard Health Systems, Inc. ("Vanguard") and PMH. PMH proposed an asset purchase transaction, while Vanguard proposed both an asset purchase transaction and a joint venture arrangement. Preferring a joint venture, GWHN pursued a relationship with Vanguard, and a Conversion Application and a CON Application were submitted. The OAG and OHCA issued decisions placing a number of conditions on the transaction, and Tenet Health Corporation (which had acquired Vanguard) withdrew the application. Ex. E, pp. 25-26, 29-30, 88-119

11. In early 2015, the Task Force requested that Cain Brothers, an investment advisory firm, look for new prospective partners. PMH was one of two candidates to indicate interest and, despite GWHN's declining financial performance, agreed to a deal similar to the proposed Tenet transaction. The Task Force approved PMH's proposed letter of intent and the Board authorized its execution, which occurred on May 1, 2015. After conducting due diligence, the Board adopted resolutions approving the transaction and the filing of the CON, as well as recommending to the various members of GWHN that they approve the transaction. On October 2, 2015, the GWHN members approved the transaction and authorized the Board to take all action to consummate the transaction. Ex. E, pp. 31-33, 88-119

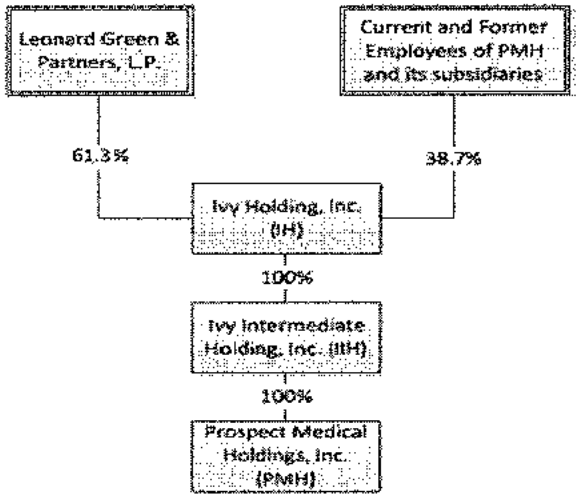
12. The Applicants are requesting approval of the proposed asset purchase (the "Asset Purchase") as a solution to GWHN's long-standing challenges that offers the Service Area continued access to its services and facilities. Ex. R, Prefiled Testimony of Carl Contadini, p. 1510

13. PMH is a for-profit, privately owned national healthcare services company with its principal place of business in Los Angeles, California. PMH owns fourteen acute care and behavioral hospitals in California, New Jersey, Rhode Island and Texas. It also owns a network of specialty and primary care clinics in each of these regions. Ex. E, pp. 18, 171-72

14. Through PMH's medical group segment, PMH also manages the provision of physician services in each of its markets through a network of approximately 8,900 physicians. The physician networks operate as independent practice associations ("IPAs") that contract with PMH-owned management service organizations ("MSOs"). The IPAs are comprised of both PMH-employed and independent community physicians. Ex. E, p. 18; Ex. R, Prefiled Testimony of Mitchell Lew, President, PMH, pp. 1605, 1607-08; Testimony of Mitchell Lew on 5/3/2016, pp. 37-38

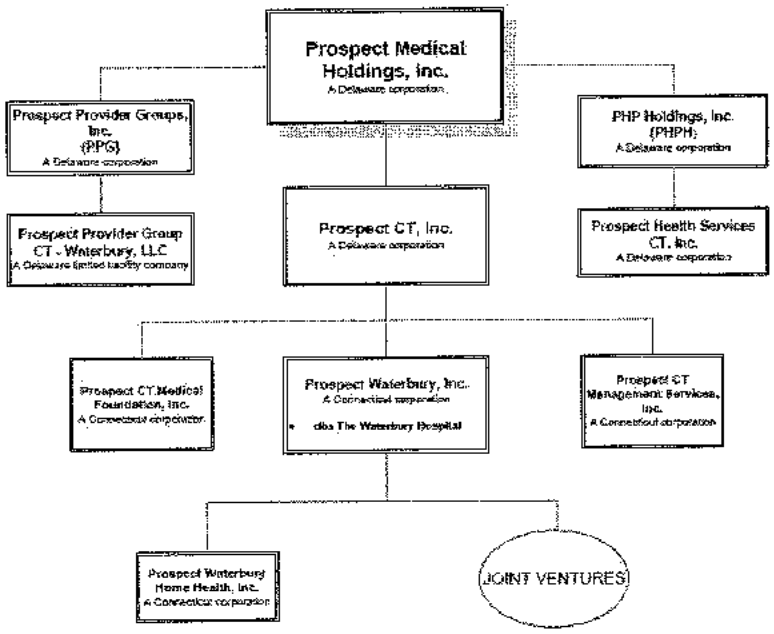
15. PMH aligns its hospitals and physicians under a model called Coordinated Regional Care ("CRC"). CRC provides for clinical integration of hospitals, physicians and community providers with health plans and other payers through value driven and risk-based reimbursement systems. PMH believes that the CRC model improves quality, efficiency and financial performance while providing its patients with quality, affordable healthcare. Ex. E, pp. 89

16. The chart below shows PMH's current ownership structure:



Ex. H, p. 1413

17. The chart below shows PMH's proposed organizational structure below the holding company level after the proposed transaction:



Ex. E, p. 68

18. GWHN selected PMH as the proposed purchaser because its financial resources and access to capital are anticipated to maintain GWHN's assets as economically viable and vibrant parts of the healthcare system in the Service Area by permitting capital investments, better preparing the Hospital to participate in new value-based delivery models, offering enhanced practice options for physicians, strengthening its network of providers and allowing for other improvements in operations. Ex. R, Prefiled Testimony of Mitchell Lew, p. 1606; of Ex. R, Prefiled Testimony of Darlene Stromstad, President & CEO, GWHN, pp. 1516-20; Ex. R, Prefiled Testimony of Von Crockett, Senior Vice President of Corporate Development, PMH, pp. 1537-39

19. In its audited financial statements for FY 2015, PMH reported total revenues of over $1.3 billion from its operations on a consolidated basis. As of fiscal year end 2015, PMH reported free cash flow of over $112 million and close to $75 million in cash from operations. The company also received credit upgrades by both Moody's and S&P in 2015, with Moody's rating PMH's bonds as B1 and S&P rating PMH's bonds as B. These ratings still stand as of May 3, 2016. Ex. R, Prefiled Testimony of Steven Aleman, Chief Financial Officer, PMH, p. 1620; Testimony of Steven Aleman, Tr. on 5/3/2016, p. 113; Docket#15-32016-486, Ex. N, pp. 3245, 3249-59; Ex. K, pp. 1445-46

20. Under the proposed Asset Purchase Agreement ("APA"), PMH will pay a total purchase price of approximately $43.3 million for the assets of GWHN, which includes a purchase price of $31.8 million plus a net working capital adjustment of $18.3 million, as of April 30, 2016, minus capital lease obligations in excess of $6.5 million, unfunded pension liabilities, asbestos abatement liability, the amounts of certain GWHN liabilities assumed by PMH, and for the value of any joint venture interest that GWHN is unable to assign or transfer. Ex. E, pp. 12, 20, 71, 147; Ex. F, p.1419; Late File 3, pp. 1848-49

21. PMH will commit to spend within seven years no less than $55 million, less (a) the amount not to exceed $3.5 million of capital lease obligations assumed by PMH at Closing in excess of $3 million, (b) the cash shortfall at closing (defined in the APA as the "Negative Amount"), (c) the Purchase Price Adjustment Shortfall, provided that the aggregate of the amounts in (b) and (c) are not to exceed $5.0 million in aggregate, and (d) unpaid indemnification losses of PMH (defined in the APA as the "Unpaid Losses") of up to $4.5 million, (the "Commitment Amount"). (Revised APA draft dated June 10, 2016, pages 1861and 1977).

22. There is no financing contingency with respect to this transaction. PMH anticipates funding this acquisition using its existing cash. PMH also has access to a preapproved $40 million revolving line of credit with Morgan Stanley and, as shown below, PMH has provided data showing that its debt leverage ratio is lower than other for-profit hospital systems.

Industry Debt Leverage Ratio Comparison	
Entity	**Ratio**
Prospect	2.71X
Hospital Corporation of America	3.7X
Community Health Systems	5.4X
Tenet	6.3X

Ex. R, Prefiled Testimony of Steven Aleman, p. 1621; Ex. E, p. 69, Ex, K, p.1445; Docket#15-32016-486, Ex. K, p. 2191

23. Closing the transaction is estimated to require only $27 million in cash from PMH. By the closing date (the "Closing" or "Closing Date"), PMH anticipates it will have close to $100 million in cash on hand as a result of its growth in revenues, which are generating $10-15 million of free cash flow on a monthly basis. The $40 million revolving line of credit, which PMH recently drew down to $10 million to finance its purchase of East Orange General Hospital in New Jersey, is also expected to be restored to $30 million by the Closing. Ex. F, p. 1419; Late File 3, p. 1849; Testimony of Steven Aleman, Tr. on 3/29/16, pp. 151-53

24. The following GWHN assets will be excluded from the transaction:

- All cash and cash equivalents;
- All short-term and long-term investments other than GWHN's investments in the joint ventures;
- Board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, working capital trust assets, and assets and investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;
- Prepaid expenses not assumed by PMH;
- All insurance proceeds arising in connection with the operation of the assets or the facilities for periods prior to Closing to the extent that all damage to the assets has been repaired;
- All amounts due or to become due to GWHN from the Medicare, Medicaid or other payor programs in respect of cost report periods ended on or prior to Closing; and
- Interests in and assets of GWHS, CCGWHN and HAIC.

Ex. E, pp. 19, 142

25. GWHN's debt and pension obligations will also be addressed as a result of the transaction. At the time of the Closing and as permitted thereafter, the purchase price (less adjustments) together with GWHN's cash, investments and debt service reserve funds (but excluding charitable funds) will be used to satisfy GWHN's obligations. GWHN's unfunded pension liabilities with respect to its multi-employer defined benefit health plan are estimated to be at least $27 million and, with respect to its cash balance plan, are approximately $12 million. Ex. F, pp. 76, 1419; Prefiled Testimony, Steven Aleman, p. 1620

26. Table 1 summarizes the net proceeds and flow of funds associated with the Asset Purchase as of April 30, 2016 compared to September 30, 2015, including GWHN's anticipated plan for payment of debt and pension obligations as well as payment of other liabilities. The amounts are subject to adjustment at Closing.

TABLE 1
APA PROJECTED NET PROCEEDS AND FLOW OF FUNDS

Proceeds Calculation	As of 9/30/2015	As of 4/30/2016*
Proceeds		
Enterprise Value	$31,800,000	$25,000,000
Working Capital Adjustment	$4,601,512	$18,258,911
Total Gross Proceeds	**$36,401,512**	**$43,258,911**

PM Assumed Liabilities		
Asbestos Abatement	($2,896,529)	($2,898,529)
Nurses Pension	($27,000,000)	($27,000,000)
Hospital Cash Balance Plan	($11,613,917)	($12,363,507)
Total Assumed Liabilities	**($41,512,446)**	**($42,262,036)**
Net Proceeds	**($5,110,934)**	**($996,875)**
Unrestricted Cash	$35,767,106	$35,174,646
Total Unrestricted Cash and Net Proceeds	**$30,656,172**	**$36,171,521**
Cash Needs at Closing		
Estimated Transaction Costs	($1,450,000)	($1,450,000)
Bank Debt	($24,094,638)	($23,783,297)
Debt Swap	($1,512,596)	($1,851,544)
Total Cash Needs at Closing	**($27,057,234)**	**($27,084,841)**
Net Cash Post Closing Liabilities & Expenses	**$3,598,937**	**$9,086,680**

*All figures are current through April 30, 2016, with the exception of the Children's Center, which is current through March 31, 2016.
Ex. E. pp 1419 and Ex. AA, Late File 3.

27. After Closing, the assets of GWHN will be transferred to Prospect Connecticut, Inc. ("New GWHN") or one or more of its affiliates. New GWHN will serve as the health system parent company and sole shareholder of Prospect Waterbury, Inc., which will hold the Hospital's license after Closing (the post-closing hospital will be referred to as "New Hospital"). Ex. E, p. 21

28. The Commitment Amount will be funded through GWHN's operating income, and any shortfall will be funded by PMH's existing cash or through PMH's corporate level credit facility. Ex. E, p. 69

29. The Commitment Amount will be dedicated to continued improvement in quality and safety, expansion of services, new services, physician and service integration, and improvements in access to service. Ex. E, p. 57

30. PMH does not currently plan to change any service lines or locations as a result of the Asset Purchase. Ex. E, p. 48

31. There is currently no capital plan related to the transaction. After Closing, PMH, in consultation with the Local Board (defined in paragraph 38 below), will develop a strategic capital plan with respect to the New Hospital and associated affiliates and joint ventures. Ex. E, p.70; Ex. R., p. 1641

32. The capital projects in Table 2 below have been identified by GWHN management as priority capital projects to be addressed within the first three years after Closing. Ex. E, p. 72

TABLE 2
CAPITAL PRIORITY PROJECTS IDENTIFIED BY GWHN

Description	Estimated Cost (In Millions)	Estimated Timeframe (In Months)
Facility – Main Campus		
Expansion of ED/Development of urgent care*	$3.75	24-36
Upgrade OB/Women's health	$2.0	6-18
Upgrade outpatient surgery**	$2.0	6-18
Equipment		
Replace interventional radiology equipment	$1.7	12-18
Upgrade surgical/anesthesia equipment	$1.5	12-18
Outpatient Centers (Southbury, Naugatuck and Waterbury)* **	N/A	N/A
Physician Recruitment	N/A	N/A
Information Technology		
Continue IT Plan	N/A	N/A
Implement outpatient/physician practice strategy	N/A	N/A
Patient Safety****	$3.24	12-36
Total Estimated Cost	**$14.2**	

No dollars have yet been assigned to outpatient centers, physician recruitment and information technology.

* The Hospital's emergency department was built to accommodate 35,000 patients annually, while actual utilization is about 50,000, resulting in lengthy patient wait times and higher than average "Left Without Being Seen" rates. Additionally, hallways are consistently used as patient rooms. Expanding the emergency department will improve access to care, decrease LWOS, and improve patient privacy. Ex. Ex. H, pp. 1416-17

** There is no separate area for outpatient surgery. Accordingly, patients are currently being redirected to outpatient surgery centers in the community. Ex. H, p. 1417

*** The Hospital currently provides several health care services in Southbury, Naugatuck, and Waterbury. PMH intends to co-locate services by developing outpatient centers in each of these towns, creating a central environment with adequate parking and convenient access for patients. Ex. H, p. 1417

**** Immediate capital needs required over the first two to three years following Closing are: monitors in the ER ($600,000), ER architects/plan ($200,000), nuclear med ($450,000), fetal monitors ($145,000), EKG ($550,000), defibrillators ($240,000), two Jackson tables ($200,000), nurse call/ED ($220,000), bed replacements ($360,000), med cart replacements ($150,000), and beginning anesthesia update ($120,000). Ex. R, p. 1640

33. Because of GWHN's poor financial condition, the projects identified in Table 2 cannot be accomplished without this transaction. Ex. R., Prefiled Testimony of Carl Contadini, p. 1510; Testimony of Darlene Stromstrad, Tr. on 5/3/2016, p. 30; Ex. R, Prefiled Testimony, Jonathan Spees, Vice President of Mergers and Acquisitions, PMH, pp. 1626-27

34. With the proposed Asset Purchase, the parties expect that PMH will provide sufficient capital to meet deferred, current and future capital needs for the Hospital's physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology. With PMH's access to capital, New Hospital will have the financial resources to purchase new technology, upgrade its facilities, attract skilled providers, and upgrade electronic health records, in addition to investing in service line development, physician alignment and recruitment and development of increasing ambulatory access. Ex. R, Prefiled Testimony, Jonathan Spees, p. 1627

35. Table 3 below represents GWHN's projected incremental operating revenues, earnings before interest, taxes, depreciation and amortization (EBITDA) and gain/losses from operations and provisions for income taxes with this proposal.

TABLE 3
GWHN PROJECTED INCREMENTAL OPERATING REVENUE, EBITDA, INCOME FROM OPERATIONS, AND PROVISION FOR INCOME TAXES WITH THE PROPOSAL

	FY 2016	FY 2017	FY 2018
Operating Revenue	$324,151	$3,702,750	$6,827,192
Earnings Before Interest, Taxes, Depreciation & Amortization (EBITDA)	$1,408,798	$3,620,294	$4,425,395
Gain/Loss from Operations	$962,989	$1,868,015	$2,256,121
Provision for Income Taxes	$785,217	$2,172,366	$2,050,340

Ex. E, p.1167

36. PMH has restored the financial position of other health systems by applying its data-driven operating strategies, leveraging its corporate capabilities and investing in system growth. Ex. R, Prefiled Testimony, Jonathan Spees, p. 1627

37. Table 4 below illustrates the financial performance of the Texas and Rhode Island hospitals after they were acquired by PMH:

TABLE 4
PMH'S RECENT ACQUISITIONS FINANCIAL PERFORMANCE (in Thousands)

Entity	EBITDA			Working Capital			Stockholder's Equity		
	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015
Nix Health System (a)	$14,905	$18,411	$8,043	$5,937	$36,785	$35,449	$13,122	$20,468	$63,789
Roger Williams Medical Center (b)	$3,942	$1,582	$9,080	($1,860)	$1,114	$6,230	$37,184	$34,099	$38,256
Our Lady of Fatima Hospital(c)	($893)	$509	$6,485	$1,904	$2,040	$3,432	($57,150)	$27,513	$28,107

(a) Nix is a Health System based in Texas. Nix's Earnings Before Interest, Taxes, Depreciation and amortization (EBITDA) is based on reported trailing twelve months ended on 1/31/2011. Declines in EBITDA between 2014 and 2015 were due to the fluctuation in net reimbursement related to payments made to the Service Organization of San Antonio "SOSA". Funding to SOSA is voluntary but it is projected to average approximately $12M a year based on budgeted spending initiatives of the service organization. In 2014 the funding requirements were $5.7M (lower by approximately $6.3M) and in 2015 funding requirements returned to $12M. The remaining difference was comprised of lower volume at the facility as services were reconfigured and medical staff turnover. Working Capital of Nix prior to acquisition is as of 1/31/2011 and includes cash which was not part of assets acquired by PMH.

(b) EBITDA for Roger Williams Medical Center ("RWMC"), located in Providence , Rhode Island, for year prior to acquisition is only for 8 months ending on May 31, 2014 and EBITDA for FY2014 is only for three months post acquisition for FYE 9/30/2014. Working capital is for prior to acquisition as of 5/31/2014 and includes cash which was not part of the assets acquired by PMH as prior to the acquisition RWMC was a non-profit organization. Therefore, net assets were used as a substitute for stockholder's equity.

(c) EBITDA for Our Lady of Fatima Hospital ("OLFH") in Rhode Island is for year prior to acquisition and is only for 8 months ending on May 31, 2014 and for FY2014 is only for three months post acquisition. Working capital prior to acquisition is as of 5/31/2014 and includes cash which was not part of the assets acquired by PMH as prior to the acquisition OLFH was a non-profit organization. Therefore, net assets were used as a substitute for stockholder's equity.

Docket#15-32016-486, Late File 19, dated Apr. 20, 2016; Docket#15-32016-486, Ex. QQ, dated May 9, 2016

38. After Closing, the New Hospital will be governed by a board of directors controlled by PMH (the "New Hospital Board"). The New Hospital Board will have oversight and ultimate authority over the affairs of the New Hospital and the purchased assets. The New Hospital Board will be composed of executives of PMH and local employed executives of GWHN. There are currently no actual or proposed bylaws for the New Hospital Board. Ex. E, p. 20; Ex. H, p. 1422

39. The New Hospital Board will be advised by a local advisory board, anticipated to be comprised of five current members of the GWHN Board, five physicians, and the CEO of the New Hospital (the "Local Board"). The Local Board will serve as a resource for PMH with respect to development and review of strategic plans, assist with maintenance and implementation of a strategic business plan for the New Hospital, and assist with medical staff credentialing, quality assurance programs and accreditation at the New Hospital. There are currently no actual or proposed Bylaws for the Local Board. Ex. E, pp. 20-21, 190; Ex. H, pp. 1422-23

40. As of the Closing Date, PMH or an affiliate will offer employment to substantially all GWHN employees who are in good standing, in positions and at salaries at least equal to those then being provided by GWHN and with benefits packages comparable to those offered to similarly-situated employees at other hospitals operated by PMH. Ex. E, pp. 86, 90, 176

41. PMH plans to establish a strong physician network by recruiting high quality physicians to GWHN's medical staff. PMH has developed significant experience in other markets regarding methods of attracting more primary care providers and improving access to care. Recently, PMH succeeded in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners participating in PMH's Rhode Island physician network at the end of 2015, only 18 were employed by the CharterCare System when PMH acquired its two hospitals (RWMC and OLFH) in mid-2014. Ex. E, p. 89; Docket#15-32016-486, Ex. G, p. 75; Ex. K, p. 2177-78

42. In order to implement the CRC strategy, PMH has established an IPA entity in Connecticut (Prospect Provider Group CT-Waterbury, LLC, or "PPGCTW") and a preferred provider network/health system risk taking entity, Prospect Health Services CT, Inc., that will contract with payers on behalf of PPGCTW physicians. These two organizations, through management services agreements with PMH, will manage physician participation, risk contracting and care management activities for participating members. Ex. E, p. 87; Ex. H, p. 1430; Ex. R, Prefiled Testimony of Mitchell Lew, p. 1605; Testimony of Mitchell Lew, Tr. on 5/3/2016, pp. 37-38

43. The goal of the CRC model is to reduce the overall cost of health care by increasing preventive care and reducing readmissions, inpatient utilization and emergency room visits. PMH will achieve these goals by developing a healthcare delivery network encompassing the entire continuum of patient care, including inpatient services, home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health related services. Ex. E, pp. 62, 89; Ex. R, Prefiled Testimony of Mitchell Lew, pp. 1607, 1609, 1611-12

44. PMH has demonstrated the efficacy of the CRC model in Southern California, Texas and Rhode Island. In these regions, PMH has improved clinical outcomes, increased quality scores, increased patient satisfaction, reduced readmission rates, reduced average lengths of stay, and reduced medical-cost ratios. For example, from 2012 to 2014 in California and Texas, where PMH participates in HMO contracts for seniors, PMH reduced hospital bed days per thousand patients from 1,260 to 720. Additionally, length of hospital stay for this population has been reduced from 5.1 to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. The CRC model has also enabled PMH to attract more primary care providers and has improved access to care. Ex. E, p. 65-66; Ex. R, Prefiled Testimony of Mitchell Lew, pp. 1608, 1610, 1615

45. PMH has agreed to adhere to GWHN's charity care policies for at least the first five years after Closing. For the first five years, PMH has also agreed to participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, provide public health programs of educational benefit to the community, and to generally promote public health, wellness, and welfare to the community by operating the New Hospital with quality standards consistent with other hospitals owned by PMH. Ex. E, pp. 61-63, 81, 1226-28; Ex. H, p. 1437; Testimony of Von Crockett, Tr. on 5/3/2016, p. 98; Tr., Testimony of Tom Reardon, President, PMH East on 5/3/16, pp. 103-04

46. PMH will continue to provide financial support for community benefit and community building activities in the Waterbury area to the same degree as GWHN did in FY 2014. The spending by PMH for community building activities post-closing is projected to increase 1% each year through FY 2019, and the spending for both community benefit and community building activities post-closing assumes no change in the Medicaid population served or the complement of community benefit programs offered by the New Hospital. Ex. E, pp. 83-84; Testimony of Jonathon Spees, Tr. on 5/3/2016, p. 104

47. Table 5 below describes the socioeconomic condition of the Service Area towns in comparison to the state of Connecticut as a whole and shows the areas most in need of such programs.

TABLE 5
SOCIOECONOMIC STATUS OF THE SERVICE AREA

Data Town	Poverty Rate	Medium Household Income	Unemployment Rate	Medium Age
Primary Service Area				
Beacon Falls	3.8%	$ 79,207	7.0%	39
Bethlehem	4.4%	$ 80,884	5.8%	50
Cheshire	2.8%	$ 110,587	6.2%	41
Middlebury	2.6%	$ 97,996	5.9%	45
Naugatuck	8.6%	$ 62,574	9.4%	39
Prospect	3.2%	$ 95,325	6.7%	44
Southbury	6.4%	$ 67,195	6.6%	50
Thomaston	2.7%	$ 67,426	7.8%	43
Waterbury	21.9%	$ 40,867	12.5%	35
Watertown	3.4%	$ 80,899	7.7%	44
Wolcott	3.4%	$ 80,655	7.8%	44
Woodbury	4.6%	$ 80,167	5.9%	48
Secondary Service Area				
Harwinton	4.6%	$ 89,429	6.1%	47
Morris	5.6%	$ 89,688	6.4%	45
Oxford	4.5%	$ 107,308	6.0%	43
Plymouth	6.7%	$ 73,603	8.9%	41
Seymour	6.8%	$ 73,099	7.7%	42

Southington	3.6%	$ 78,668	6.4%	44
Torrington	11.2%	$ 50,548	8.5%	43
State	**10.0%**	**$ 69,519**	**7.8%**	**40**

Ex. E, p. 54

48. Central Waterbury is designated as a Medically Underserved Area and a Health Professionals Shortage Area. The Hospital currently provides safety net services in this area. The Applicants anticipate that the proposed Asset Purchase will support the availability of health care services to vulnerable populations in the Service Area. Ex. E, p. 54

49. In 2013, the Hospital conducted a Community Health Needs Assessment ("CHNA"), which identified current and future health care needs of the community. The priority areas identified for the greater Waterbury community were access to care, mental health/substance abuse, overweight/obesity, and smoking/tobacco use. An implementation plan was developed to respond to the identified health needs, which PMH has agreed to support. Additionally, the Hospital has traditionally taken a lead role in developing the CHNA, and PMH has agreed to maintain GWHN's current level of involvement in developing and implementing the CHNA for five years from Closing. Ex. E, pp. 60, 62, 1075-1129, 1130-49; Ex. H, p. 1439; Testimony of Von Crockett, Tr. on 5/3/2016, pp. 90-91

50. PMH has also stated that the New Hospital will be in compliance with the following general community benefit standards for at least the first three years after the Closing: (a) the New Hospital will have an open medical staff and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors and (b) the New Hospital will operate a 24/7 emergency department and provide emergency services to patients regardless of their ability to pay. Testimony of Tom Reardon, Tr. on 5/3/16, pp. 103-04

51. PMH and GWHN representatives have already met with leadership for Connecticut's Medicaid Program at the Department of Social Services ("DSS") and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. PMH is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state. In addition, PMH will actively work with other providers in the community such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the Service Area, including Medicaid recipients. Ex. E, pp. 63-65

52. The patient population currently served by the Hospital is not expected to change as a result of the Asset Purchase. PMH will accept all existing contracts with payers and will complete a change of ownership process with commercial payers, as well as Medicare and the Connecticut Medical Assistance Program (Medicaid). Table 6 below describes the current and projected patient population and payer mix for the Hospital with respect to discharges.

TABLE 6
PATIENT POPULATION/PAYER MIX

Hospital	YTD 8/31/15	Projected 2015	Projected FY 2016	Project FY 2017	Projected FY 2018
Medicare	5,002	5,457	5,312	5,312	5,312
Medicaid	3,021	3,296	3,196	3,196	3,196
CHAMPUS or TriCare	18	19	18	18	18
Total Government Payers	8,041	8,771	8,526	8,526	8,526
Commercial Insurers	2,527	2,757	2,681	2,681	2,681
Self-Pay	113	123	64	64	64
Workers Compensation	61	67	73	73	73
Total Non-Government Payers	2,701	2,947	2,818	2,818	2,818
Total Payer Mix	**10,742**	**11,718**	**11,344**	**11,344**	**11,344**

Ex. E, pp. 74, 76

53. Financial benefits associated with this proposal include: operational efficiencies and economies of scale, the New Hospital's participation in PMH's purchasing power, supply chain benefits, employee benefits savings and streamlined revenue collection. PMH also makes available to its hospitals subject matter consultants who are employed by PMH, saving its hospitals the cost of hiring consultants in those areas. Ex. R, Prefiled Testimony of Von Crockett, p. 1535; Docket#15-32016-486, Ex. N., p. 3236

54. PMH has agreed to maintain GWHN's quality program for at least two years following the transaction. Ex. T, p. 1826; Ex. R., Prefiled Testimony of Von Crockett, p. 1533

55. PMH has had to significantly modify its own Quality Assurance and Performance Improvement ("QAPI") as a result of recent surveys of two PMH hospitals in California, Los Angeles Community Hospital and Southern California Hospital, resulting in the California Department of Health imposing Immediate Jeopardy citations. Ex. K, p. 1459-61; Ex. R, Prefiled Testimony of Von Crockett, pp. 1530-33

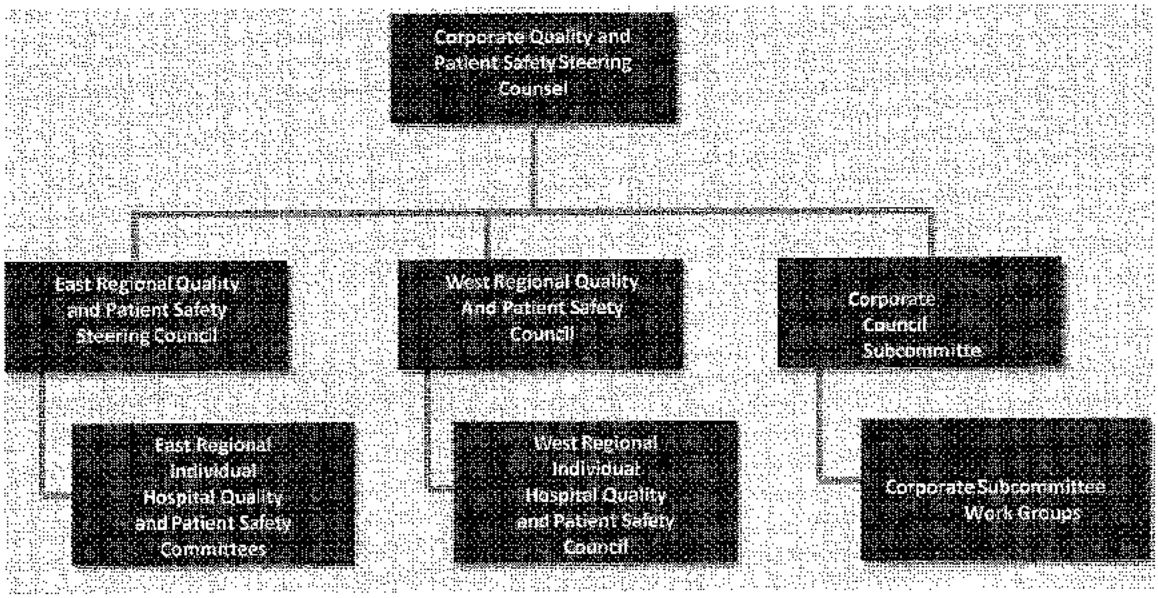
56. GWHN representatives learned of the Immediate Jeopardy citations on February 11, 2016. In response, the GWHN Board appointed a task force to review the citations and corrective actions taken and to recommend whether or not to proceed with the transaction. The task force reviewed the deficiencies and corrective action plans, conducted interviews, and made site visits to PMH-owned hospitals in both California and Rhode Island. The task force determined that PMH was committed to quality and proposed that GWHN obtain certain assurances from PMH and move forward with the transaction. Ex. R, pp. 1635-36; Testimony, Susan Cordeau, Director of Performance Improvement, GWHN, Tr. on 5/3/2016, pp. 25-31

57. Accordingly, on April 27, 2016 the parties entered into a Quality Assurance Commitment Letter pursuant to which PMH agreed to maintain certain GWHN quality programs for the first two years after the Closing Date and to not modify them without approval of the Local Board. The Quality Assurance Commitment Letter also requires that PMH maintain QAPI programs consistent with best practices and those currently implemented in PMH's Rhode Island facilities while also acknowledging that the Local Board shall oversee quality programs at the New Hospital. Ex. T, p. 1826

58. Based on the information learned and protections gained, the task force recommended, and the Board confirmed, GWHN's commitment to proceed with the transaction. Ex. R, pp. 1635-36; Testimony, Susan Cordeau, Tr. on 5/3/2016, pp. 30-31

59. Additionally, as a result of the Immediate Jeopardy citations, PMH has hired a corporate level Chief Quality Officer, Chief Clinical Officer, Chief Nursing Officer and an Associate Vice President of Regulatory and Patient Safety to assist in providing necessary resources to implement all quality programs at its local hospitals and share best practices among the hospitals. Ex. K, p. 1459; Ex. R, Prefiled Testimony of Von Crockett, pp. 1530-32

60. Other PMH initiatives include retaining a national consulting firm and legal counsel to assist in preparedness and responses to Centers for Medicare and Medicaid Services ("CMS") surveys. Under PMH's draft QAPI program, a Hospital Quality & Patient Safety Committee will be developed at the New Hospital, with oversight over subcommittees and workgroups that address the New Hospital's unique needs. These committees will report to a Regional Quality and Patient Safety Steering Council, which will report to the Corporate Quality and Patient Safety Steering Council, as described below:



Testimony of Debbie Berry, Chief Quality Officer, PMH, pp. 57-59; Ex. R, pp. 1692, 1696; Docket#15-32016-486, Tr., Testimony of Von Crockett on 3/29/15, pp. 93-94; Docket#15-32016-486, Ex. Z, Prefiled Testimony of Von Crockett, pp. 3356-57; Docket#15-32016-486, Ex. Z, pp. 3402-03; Docket#15-32016-486, Late File I, dated Apr. 20, 2016; Docket#15-32016-486, Late File 10, dated Apr. 20, 2016

61. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. Conn. Gen. Stat. § 19a-639(a)(1)

62. The application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. Conn. Gen. Stat. § 19a-639(a)(2)

63. The Applicants have established that there is a clear public need for the proposal. Conn. Gen. Stat. §19a-639(a)(3)

64. The Applicants have demonstrated that the proposal will improve the overall financial strength of the health care system and that it is financially feasible. Conn. Gen. Stat. §19a-639(a)(4)

65. Subject to the conditions below, the Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. Conn. Gen. Stat. §19a-639(a)(5)

66. Subject to the conditions below, the Applicants have shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. Conn. Gen. Stat. §19a-639(a)(6)

67. The Applicants have satisfactorily identified the population to be affected by this proposal. Conn. Gen. Stat. §19a-639(a)(7)

68. The historical utilization of GWHN's services in the Service Area support this proposal. Conn. Gen. Stat. §19a-639(a)(8)

69. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. Conn. Gen. Stat. §19a-639(a)(9)

70. Subject to the conditions below, the Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. Conn. Gen. Stat. §19a-639(a)(10)

71. The Applicants have satisfactorily demonstrated that the proposal will not have a negative impact on the diversity of health care providers in the area. Conn. Gen. Stat. §19a-639(a)(11)

72. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. Conn. Gen. Stat. §19a-639(a)(12)

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 considered the factors set forth in Connecticut General Statutes § 19a-639(a) and 19a-486d. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board,* 309 Conn. 727 (2013).

GWHN is a non-stock, 501(c)(3) corporation that is the parent company to The Waterbury Hospital ("Hospital"), an acute care teaching hospital with 357 licensed beds plus 36 bassinets located in Waterbury, Connecticut. GWHN also holds interests in other entities, joint ventures, and affiliates. *FF1* GWHN serves the following towns: Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury. *FF6* PMH is a for-profit, privately owned national healthcare services company with its principal place of business in Los Angeles, California. PMH owns fourteen acute care and behavioral hospitals in California, New Jersey, Rhode Island and Texas. It also owns a network of specialty and primary care clinics in each of these regions. *FF13* The Hospital has experienced consecutive years of losses due to poor economic conditions in the Service Area, declining government and commercial reimbursement, the increasing complexity of health care treatment, and national health care reform. Additionally the recession in 2008 led to GWHN defaulting on its bond covenants in 2009. In 2010, a consulting firm, Kaufman Hall, identified over $50 million in capital improvements required over five years to keep the Hospital operational. *FF7* The Applicants are requesting approval of the proposed asset purchase (the "Asset Purchase") as a solution to GWHN's long-standing challenges that offers the Service Area continued access to its services and facilities. *FF12*

Under the proposed Asset Purchase Agreement ("APA"), PMH will pay a total purchase price of approximately $43.3 million for the assets of GWHN, which includes a purchase price of $31.8 million plus a net working capital adjustment of $18.3 million, as of April 30, 2016, minus capital lease obligations in excess of $6.5 million, unfunded pension liabilities, asbestos abatement liability, the amounts of certain GWHN liabilities assumed by PMH, and for the value of any joint venture interest that GWHN is unable to assign or transfer. *FF20* PMH will commit to spend within seven years no less than $55 million, less (a) the amount not to exceed $3.5 million of capital lease obligations assumed by PMH at Closing in excess of $3 million, (b) the cash shortfall at closing (defined in the APA as the "Negative Amount"), (c) the Purchase Price Adjustment Shortfall, provided that the aggregate of the amounts in (b) and (c) are not to exceed $5.0 million in aggregate, and (d) unpaid indemnification losses of PMH (defined in the APA as the "Unpaid Losses") of up to $4.5 million, (the "Commitment Amount"). *FF21* GWHN's debt and pension obligations will also be addressed as a result of the transaction. At the time of the Closing and as permitted thereafter, the purchase price (less adjustments) together with GWHN's cash, investments and debt service reserve funds (but excluding charitable funds) will be used to satisfy GWHN's obligations. GWHN's unfunded pension liabilities with respect to its multi-

employer defined benefit health plan are estimated to be at least $27 million and, with respect to its cash balance plan, are approximately $12 million. *FF25*

With the proposed Asset Purchase, the parties expect that PMH will provide sufficient capital to meet deferred, current and future capital needs for the Hospital's physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology. With PMH's access to capital, the post-closing New Hospital will have the financial resources to purchase new technology, upgrade its facilities, attract skilled providers, and upgrade electronic health records, in addition to investing in service line development, physician alignment and recruitment and development of increasing ambulatory access. *FF34* On the Closing Date, the assets of GWHN will be transferred to Prospect Connecticut, Inc. ("New GWHN") or one or more of its affiliates. New GWHN will serve as the health system parent company and sole shareholder of Prospect Waterbury, Inc., which will hold the Hospital's license after Closing (the post-closing hospital will be referred to as "New Hospital"). *FF27*

Following Closing, the New Hospital will be governed by a board of directors controlled by PMH (the "New Hospital Board"). The New Hospital Board will have oversight and ultimate authority over the affairs of the New Hospital and the purchased assets. The New Hospital Board will be composed of executives of PMH and local employed executives of GWHN. *FF38* The New Hospital Board will be advised by a local advisory board, anticipated to be comprised of five current members of the GWHN Board, five physicians, and the CEO of the New Hospital (the "Local Board"). The Local Board will serve as a resource for PMH with respect to development and review of strategic plans, assist with maintenance and implementation of a strategic business plan for the New Hospital, and assist with medical staff credentialing, quality assurance programs and accreditation at the New Hospital. *FF39*

The capital projects in the table below have been identified by GWHN management as priority capital projects to be addressed within the first three years after Closing. *FF32*

CAPITAL PRIORITY PROJECTS IDENTIFIED BY GWHN

Description	Estimated Cost (In Millions)	Estimated Timeframe (In Months)
Facility – Main Campus		
Expansion of ED/Development of urgent care*	$3.75	24-36
Upgrade OB/Women's health	$2.0	6-18
Upgrade outpatient surgery**	$2.0	6-18
Equipment		
Replace interventional radiology equipment	$1.7	12-18
Upgrade surgical/anesthesia equipment	$1.5	12-18
Outpatient Centers (Southbury, Naugatuck and Waterbury)* **	N/A	N/A
Physician Recruitment	N/A	N/A
Information Technology		
Continue IT Plan	N/A	N/A

Implement outpatient/physician practice strategy	N/A	N/A
Patient Safety****	$3.24	12-36
Total Estimated Cost	**$14.2**	

PMH plans to establish a strong physician network by recruiting high quality physicians to GWHN's medical staff. PMH has developed significant experience in other markets regarding methods of attracting more primary care providers and improving access to care. Recently, PMH succeeded in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners participating in PMH's Rhode Island physician network at the end of 2015, only 18 were employed by the CharterCare System when PMH acquired its two hospitals (RWMC and OLFH) in mid-2014. *FF41*

With respect to its quality of health care services, PMH has had to significantly modify its Quality Assurance and Performance Improvement ("QAPI") as a result of recent surveys of two PMH hospitals in California, Los Angeles Community Hospital and Southern California Hospital, resulting in the California Department of Health imposing Immediate Jeopardy citations. *FF55* GWHN representatives learned of the Immediate Jeopardy citations on February 11, 2016. In response, the GWHN Board appointed a task force to review the citations and corrective actions taken and to recommend whether or not to proceed with the transaction. The task force reviewed the deficiencies and corrective action plans, conducted interviews, and made site visits to PMH-owned hospitals in both California and Rhode Island. The task force determined that PMH was committed to quality and proposed that GWHN obtain certain assurances from PMH and move forward with the transaction. *FF56* Accordingly, on April 27, 2016 the parties entered into a Quality Assurance Commitment Letter pursuant to which PMH agreed to maintain certain GWHN quality programs for the first two years after the Closing and to not modify them without approval of the Local Board. The Quality Assurance Commitment Letter also requires that PMH maintain QAPI programs consistent with best practices and those currently implemented in PMH's Rhode Island facilities while also acknowledging that the Local Board shall oversee quality programs at the New Hospital. *FF57*

PMH aligns its hospitals and physicians under a model called Coordinated Regional Care ("CRC"). CRC provides for clinical integration of hospitals, physicians and community providers with health plans and other payers through value driven and risk-based reimbursement systems. PMH believes that the CRC model improves quality, efficiency and financial performance while providing its patients with quality, affordable healthcare. *FF15* The goal of the CRC model is to reduce the overall cost of health care by increasing preventive care and reducing readmissions, inpatient utilization and emergency room visits. PMH will achieve these goals by developing a healthcare delivery network encompassing the entire continuum of patient care, including inpatient services, home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health related services. *FF43* PMH has demonstrated the efficacy of the CRC model in Southern California, Texas and Rhode Island. In these regions, PMH has improved clinical outcomes, increased quality scores, increased patient satisfaction, reduced readmission rates, reduced average lengths of stay, and reduced medical-cost ratios. For example, from 2012 to 2014 in California and Texas, where

PMH participates in HMO contracts for seniors, PMH reduced hospital bed days per thousand patients from 1,260 to 720. Additionally, length of hospital stay for this population has been reduced from 5.1 to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. The CRC model has also enabled PMH to attract more primary care providers and has improved access to care. *FF44*

In addition to addressing any quality issues, PMH has also agreed to adhere to GWHN's charity care policies for at least the first five years after Closing. For the first five years, PMH has also agreed to participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, provide public health programs of educational benefit to the community, and to generally promote public health, wellness, and welfare to the community by operating the New Hospital with quality standards consistent with other hospitals owned by PMH. *FF45* PMH will continue to provide financial support for community benefit and community building activities in the Waterbury area to the same degree as GWHN did in FY 2014. The spending by PMH for community building activities post-closing is projected to increase 1% each year through FY 2019, and the spending for both community benefit and community building activities post-closing assumes no change in the Medicaid population served or the complement of community benefit programs offered by the New Hospital. *FF46*

In 2013, the Hospital conducted a Community Health Needs Assessment ("CHNA"), which identified current and future health care needs of the community. The priority areas identified for the greater Waterbury community were access to care, mental health/substance abuse, overweight/obesity, and smoking/tobacco use. An implementation plan was developed to respond to the identified health needs, which PMH has agreed to support. Additionally, the Hospital has traditionally taken a lead role in developing the CHNA, and PMH has agreed to maintain GWHN's current level of involvement in developing and implementing the CHNA for five years from the Closing. *FF49* PMH has also stated that the New Hospital will be in compliance with the following general community benefit standards for at least the first three years after the Closing: (a) the New Hospital will have an open medical staff and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors and (b) the New Hospital will operate a 24/7 emergency department and provide emergency services to patients regardless of their ability to pay. *FF50* PMH and GWHN representatives have already met with leadership for Connecticut's Medicaid Program at the Department of Social Services ("DSS") and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. PMH is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state. In addition, PMH will actively work with other providers in the community such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the Service Area, including Medicaid recipients. *FF51*

Financial benefits associated with this proposal include: operational efficiencies and economies of scale, the New Hospital's participation in PMH's purchasing power, supply chain benefits, employee benefits savings and streamlined revenue collection. PMH also makes available to its

hospitals subject matter consultants who are employed by PMH, saving its hospitals the cost of hiring consultants in those areas. *FF53*

In its audited financial statements for FY 2015, PMH reported total revenues of over $1.3 billion from its operations on a consolidated basis. As of fiscal year end 2015, PMH reported free cash flow of over $112 million and close to $75 million in cash from operations. The company also received credit upgrades by both Moody's and S&P in 2015, with Moody's rating PMH's bonds as B1 and S&P rating PMH's bonds as B. These ratings still stand as of May 3, 2016. *FF19*

Based upon the aforementioned discussion of the evidence provided by the Applicants in this matter, the Applicants have satisfactorily demonstrated that PMH has made a commitment to provide health care to the uninsured and the underinsured; safeguard procedures are in place to avoid a conflict of interest in patient referral; and certificate of need authorization is justified in accordance with the principles and guidelines set forth in Connecticut General Statutes § 19a-639; those being, access to healthcare services, quality of the healthcare services, public need for the proposed project, and the financial feasibility of the proposed project.

Order

Based upon the foregoing Findings of Fact and Discussion, I respectfully recommend that the Applicants' request for the sale of substantially all of the assets of GWHN and its controlled affiliates to PMH or one or more affiliates of PMH be **Approved** under Conn. Gen. Stat. §§ 19a-486 and 19a-639 subject to the enumerated conditions (the "Conditions") set forth below.

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns, regardless of whether New GWHN remains the parent company and sole shareholder of the New Hospital. OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, including, but not limited to, Conn. Gen. Stat. § 19a-486g and the right to impose and collect a civil penalty under Conn. Gen. Stat. § 19a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. Within twenty (20) days following the Closing of the Asset Purchase authorized by this Order, Applicants shall submit a schedule to OHCA setting forth Waterbury Hospital's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the Decision Date and publish this same information on the website of the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(8) & (11); FF 18, 30*

2. Within twenty (20) days following the Closing of the Asset Purchase authorized by this Order, Applicants shall identify and provide the Certificate of Incorporation for the PMH affiliated entity that shall directly own, operate and hold the hospital license of the New Hospital post-closing. This entity shall be duly organized and validly existing under the laws of Connecticut and New GWHN shall be its parent company and sole shareholder as proposed in the CON application. OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(8) & (11); FF 27*

3. Applicants shall notify OHCA in writing of the Closing of the Asset Purchase authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:

    a. the APA, including any and all schedules and exhibits; and

    b. Bylaws or similar governance documents for New GWHN, as well as for the New Hospital.

The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If the Applicants redact materials in accordance with the previous sentence, the Applicants shall provide a list to OHCA which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a) & 19a-613(b); FF 20, 21, 38, 39*

4. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement GWHN's 2016 CHNA and for conducting the New Hospital's next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following:

   (i) the data that will be collected and analyzed to systematically assess health status indicators of the Service Area;
   (ii) the identity of key community stakeholders and health organizations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation;
   (iii) the qualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined;
   (iv) the frequency with which the Study will be repeated;
   (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the community; and
   (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospital.

   OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3) & (7); FF 49*

5. Within three (3) years following the Closing, PMH shall participate with New GWHN and the New Hospital, and the key community stakeholders and health organizations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/hct2020/hct2020_state_hlth_impv_032514.pdf), as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on New Hospital's website. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement GWHN's current CHNA for the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 49*

6. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospital for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 30, 34, 43, 46*

7. Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website of the New Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 30*

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of enhancing the understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and using evidence-based interventions.

8. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New Hospital and its affiliates from the Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project;

    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and

    c. The dates and amounts of withdrawals from the New Hospital's operating account and/or any other sources of funding used to fulfill the Capital Commitment.

    The reports shall be signed by the New GWHN's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 29, 31-34*

9. For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for New GWHN and the New Hospital, respectively:

    a. The cost saving totals achieved in the following Operating Expense Categories for New GWHN and New Hospital: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

        1. the major cost savings achieved for each expense category for the semi-annual period; and

        2. the effect of these cost savings on the clinical quality of care.

    b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New GWHN and New Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 29, 31-34*

10. For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New GWHN and New Hospital, respectively. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report:

Financial Measurement/Indicators

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

3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 18, 36*

11. PMH shall ensure that the New Hospital maintains and adheres to GWHN's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, adopt other policies that are at least as generous and benevolent to the community as GWHN's current policies consistent with state and federal law. These policies shall be posted on the website of the New Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45, 46*

12. For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of the New Hospital within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of the New Hospital simultaneously with its submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45, 46*

13. PMH shall maintain community benefit programs and community building activities for the New Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as GWHN's current programs, and PMH shall apply a 1% increase per year for the next three (3) years toward community building activities in terms of dollars spent.

In determining the New Hospital's participation and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the Closing for three years and shall be posted on New Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 46*

14. The New Hospital agrees to comply with the following general community benefit standards for at least the first three years following the Closing: (a) the New Hospital shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospital shall have an open medical staff and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors; (c) the New Hospital shall participate in the Medicare and Medicaid programs; and (d) the New Hospital shall operate a 24/7 emergency department and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45, 50*

15. The New Hospital shall work toward making culturally and linguistically appropriate services available and integrated throughout its hospital operations. Specifically, the New Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the New Hospital shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the New Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the Closing for three years and shall be posted on the New Hospital's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45-50*

16. Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who has experience in hospital administration and regulation, including maintaining quality control in an HRO. The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to the New Hospital and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486d(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 18, 34, 45-50, 57*

17. The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of the New Hospital on no less than a semi-annual basis to assess PMH's modified QAPI program and compliance with the Quality Assurance Commitment Letter. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486d(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 18, 34, 45-50, 57*

18. If at any time within three (3) years following the Closing Date, the New Hospital's Local Board agrees with PMH to change any of GWHN's Post Closing Quality Practices described in the Quality Assurance Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and FLIS in writing within thirty (30) days of any such change going into effect. If the Independent Monitor disagrees with the change, OHCA may require that a request for modification be submitted and approved as required by C.G.S. §4-18la to make the change. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 57*

19. For three (3) years following the Closing Date, PMH shall hold a meeting of the New Hospital Board and the Local Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospital's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 38, 39*

20. For three (3) years following the Closing Date, PMH shall allow for one (1) community representative to serve as a voting member of the Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representative shall be selected in consultation with the Mayor of Waterbury in order to ensure the appointment of an unbiased person who will fairly represent the interests of the community served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 38, 39*

21. PMH, New GWHN and the New Hospital shall abide by all requirements of licensure that may be imposed by FLIS in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 54, 57*

Based upon the foregoing, I respectfully recommend that the CON application for the Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc. be approved.

6/24/16
Date

Kevin Hansted, Esq.
Hearing Officer

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, July 01, 2016 3:08 PM
To: Greer, Leslie
Cc: Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: Fw: GWHN/Prospect Proposed Asset Purchase Agreement (A.G. Docket No. 15-486-02)
Attachments: Attorney General 7.01.2016 (S7011149).pdf

Leslie,

For the record.

Thanks,
Steve

From: Anne D. Peterson <APeterson@carmodylaw.com>
Sent: Friday, July 1, 2016 2:48:02 PM
To: Hawes, Gary W.; Martone, Kim; Lazarus, Steven; Cotto, Carmen
Cc: Ann H. Zucker; mmv@bvmlaw.com; Kathleen Gedney (kgg@bvmlaw.com); Jonathan.Spees@prospectmedical.com; dstromstad@wtbyhosp.org
Subject: GWHN/Prospect Proposed Asset Purchase Agreement (A.G. Docket No. 15-486-02)

Dear Gary, Kimberly, Steven and Carmen:

Please see attached comments on the proposed decision of the Office of the Attorney General in the above referenced matter. Thank you for your consideration.

Anne

Anne D. Peterson | Bio
Carmody Torrance Sandak & Hennessey LLP
195 Church Street | P.O. Box 1950
New Haven, CT 06509-1950
Direct: 203-784-3104 | Fax: 203-784-3199
APeterson@carmodylaw.com www.carmodylaw.com

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HTML

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Ann H. Zucker
Partner
707 Summer Street, 3rd Floor
Stamford, Connecticut 06901

203.252.2652
azucker@carmodylaw.com

July 1, 2016

Office of the Attorney General
55 Elm St.
P.O. Box 120
Hartford, CT 06141-0120
Attn: Atty. Gary W. Hawes, Assistant Attorney General

Re: Greater Waterbury Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; Attorney General Docket Number: 15-486-02 (the "Dockets")

Dear Mr. Hawes :

We reference the proposed decision of the Office of the Attorney General issued June 24, 2016 in the above referenced docket.

We note the following minor items for your consideration:

1. References to the reduction in the Capital Commitment could be clarified to refer to the APA for additional details:

   A. Pursuant to the APA, PMH will commit to spend not less than $55,000,000 on capital items over seven years less certain amounts such as capital leases in excess of $3,000,000, the cash shortfall of GWHN at closing and certain post closing losses, all as more particularly described in the APA. (Page 5, the last sentence of the first full paragraph).

   B. Subject to the limitations set forth in the APA, the Commitment Amount may be reduced as a result of capital lease obligations greater than $3,000,000, a GWHN cash shortfall at closing and /or for unpaid losses. (Page 19, the last sentence of the last full paragraph).

2. The legal name of the hospital that is the subject of the Docket is "The Waterbury Hospital".

3. The Proposed Decision describes the activities of the group that reviewed PMH's quality issues. Please note that this group was comprised not only of physicians but also included The Waterbury Hospital's Chief Nursing Officer and the Director of Performance Improvement. Not all of the members of this group visited both the California and Rhode Island hospitals.

Thank you and your colleagues for your professionalism and diligence in reviewing this Application.

CARMODY
TORRANCE | SANDAK | HENNESSEY LLP

Please feel free to contact Ann Zucker at (203) 252-2652 or Michele Volpe at (203) 777-6995. Thank you for your assistance in this matter.

Very truly yours,

Carmody Torrance Sandak & Hennessey LLP

By: _____
Ann H. Zucker
Its Partner

cc. Kimberly Martone, Director of Operations, Department of Public Health
Division of Office of Health Care Access
Jonathan Spees, Prospect Medical Holdings, Inc. (via email)
Darlene Stromstad, Greater Waterbury Health Network, Inc. (via email)

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, July 05, 2016 10:35 AM
To: Michele Volpe (mmv@bvmlaw.com); Ann H. Zucker
Cc: Martone, Kim; Greer, Leslie
Subject: FW: Comment on draft CON
Attachments: waterburyhospCON.docx; ATT00001.txt

Michele and Ann,

Please see the proposed comments submitted to OHCA on July 1, 2016, related to OHCA Docket Number: 15-32017-486.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

-----Original Message-----
From: Martone, Kim
Sent: Tuesday, July 05, 2016 9:17 AM
To: Lazarus, Steven
Cc: Greer, Leslie
Subject: FW: Comment on draft CON

Kimberly R. Martone
Director of Operations, Office of Health Care Access Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

-----Original Message-----
From: Bonnie Odiorne [mailto:bonniesophia@sbcglobal.net]
Sent: Friday, July 01, 2016 6:54 PM
To: Martone, Kim

Subject: Comment on draft CON

Please see attached.
Bonnie Odiorne

Naugatuck Valley Project, Inc.

16 Church Street, Waterbury, CT 06702
Phone: 203-574-2410 Fax: 203-757-8643
Email: nvpofficemanager@gmail.com website: naugatuckvalleyproject.org

June 30, 2016

□im Martone, Director of Operations
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Ms. Martone,

Waterbury Hospital has been an important part of our community institutions since its beginning as a grass roots effort based in local churches. Our communities of faith have clearly stated that health care is a right for all.

Naugatuck Valley Project (NVP) and its member organi□ations, composed of faith communities, labor unions, and other community based entities, has always focused on just treatment of all members of our communities in the valley. As a representative of NVP I am asking that the final version of the OCHA CON has as conditions a *signed* Community Benefits Agreement and an extension of charity care, Medicare and Medicaid for *five* years with a possibility for extending that period.

For the last four plus years we have struggled to protect the best practices of our local non-profit hospital that has been working to be ac□uired by a for profit entity. Our goal has been to support continuity of care for all, as well as protections for hospital workers. We need your help to encourage strong community care, community and worker stability of the largest employer in the city of Waterbury Our goal has *not* been obstruction, but rather a concern that Waterbury Hospital continue its important role in the economies and care of its community

A signed Community Benefits agreement as well as a five-year commitment to the un- and under-insured highlights Prospect Medical□s responsibility to the community it serves. We also support Prospect□s paying all property taxes rather than receiving an abatement to offset State support for a not-for-profit entity. A for-profit hospital should not incur a loss of revenue to the city. Hospital workers□agreements must be honored to prevent further economic harm to the city□s tax base.

We need you to use your power to issue the Certificate of Need to make a signed community benefits agreement as a condition of issuing the CON. This is the type of direct accountability that we need to promote a hospital that will ensure the continued access to health care services for all patient populations. A few areas covered by our proposed community benefits agreement not ade□uately addressed in OCHA□s proposed final decision are:

- Maintaining participation in Medicaid and Medicare for a minimum of five years and discussing continuing beyond that with the community
- Maintaining hospital staffing according to state law
- Paying local property taxes for the full amount of the Hospital□s value
- Completing facility based transparency similar to the IRS 990 form regarding finances, staffing and services provided using the Waterbury Health Department website

We believe that the government□s role is to help build a better future by promoting the general welfare. We believe that a signed community benefits agreement should be part of this policy. Our community cannot take on a □9 billion corporation alone; you can make the difference.

We have an opportunity to create a community benefit □one where this healthcare corporation meets the needs of the community, creates and protects good jobs, provides □uality services, maintains justice on the job for the workers, and contributes its fair share toward public needs and complies with local state and federal laws.

We hope that you will join us in this effort

Sincerely,

Bonnie Odiorne

Bonnie Odiorne, PhD
First Vice President, Naugatuck Valley Project

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, July 05, 2016 10:35 AM
To: Michele Volpe (mmv@bvmlaw.com); Ann H. Zucker
Cc: Martone, Kim; Greer, Leslie
Subject: FW: Comment on draft CON
Attachments: waterburyhospCON.docx; ATT00001.txt

Michele and Ann,

Please see the proposed comments submitted to OHCA on July 1, 2016, related to OHCA Docket Number: 15-32017-486.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

-----Original Message-----
From: Martone, Kim
Sent: Tuesday, July 05, 2016 9:17 AM
To: Lazarus, Steven
Cc: Greer, Leslie
Subject: FW: Comment on draft CON

Kimberly R. Martone
Director of Operations, Office of Health Care Access Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

-----Original Message-----
From: Bonnie Odiorne [mailto:bonniesophia@sbcglobal.net]
Sent: Friday, July 01, 2016 6:54 PM
To: Martone, Kim

Subject: Comment on draft CON

Please see attached.
Bonnie Odiorne

From: steven schrag [mailto:stevenschrag@comcast.net]
Sent: Friday, July 01, 2016 3:15 PM
To: Martone, Kim
Cc: kevin.p.lembo@gmail.com; Joan Hartley; Joe.Markley@cga.ct.gov; Anthony.DAmelio@housegop.ct.gov; jag4lbb@aol.com; Jeffrey Berger personal email ; Selim.Noujaim@housegop.ct.gov; gerry reyes; jperez@chcaunion.org; athompson@seiu1199ne.org; brown7489@att.net; Diomedes Tsitouras; Elizabeth Rosa; francesmarcuse@yahoo.com; Jack Gorman; james monroe; jim rollins; JVergauwen@snet.net; kit salazaar smith; Larry Dorman; linda.wallace71@yahoo.com; Lovan Collins; maryiorio@sbcglobal.net; Matt O'Connor; MsVickyE01@aol.com; nelsida collado; oct191706710@yahoo.com; Peter Marcuse; Ramona Barnes; Rev. Lionel French; smagro@seiu1199ne.org; Suzanne Clark; suzanneh@cea.org; tswan@igc.org; Alex Renesko; angela aybar; Bonnie Ordione; Cooney, John; Danny Blinderman; evelyn3576@aol.com; IVP Gmail; nvp@conversent.net; 'ramona barnes'; alphastarcs@gmail.com; agostino fonseca; Banita Brewer; bob parziale; carlococca@sbcglobal.net; ctorganizer@sbcglobal.net; David Dal Zin; ed hawthorne; jeremy zeedyk; jesse malena; jessica petronella; jose rivera; joseph bouchard; joseph conforti; k.bayly@sbcglobal.net; kimberly keane; Lori pellitier; Mary Florio; Patsy Sorrentino; rbenham@ctaflcio.org; rhaxhi2@waterbury.k12.ct.us; Rich Golembiewski; robert maggi; ROBERT PETRO; robert rogers; ron mclellan; sall@council4.org; shirley nwachukwu; smacs@optonline.com; steve curran; steve rice; sue fulton; thomas lorme; troy poynton; walter magnavice; wayne decarlo; will phelan
Subject: Community United comments on proposed CON for Prospect Medical Holdings and Waterbury Hospital

Community United for Jobs, Healthcare and Opportunity
c/o NVP 16 Church Street Waterbury, CT 06702

July 1, 2016

Jim Martone, Director of Operations
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Ms. Martone,

Waterbury Hospital has been a community institution since its birth was made possible with the pennies and nickels collected in local churches. This self-help bootstrap philosophy is consistent with Waterbury's history and part of the story of our country.

Since the beginning of our country we have been charting a course that has led to expanding our liberty and the empowerment of the individual. One example is the right to vote. Decades of struggles led to enfranchisement for white men who did not own property, African Americans, women and 18-21 year olds. Now is the time to take another step in that tradition of increasing our liberty and power by requiring healthcare institutions to be directly accountable to the community that they serve.

For the last 4 plus years we have struggled to move forward by protecting what are the best elements of our local non-profit hospital. We need your help, we cannot do it alone.

We have met with hospital officials and they have refused to be directly accountable to the community through the most important tool used by all businesses, a written contract. We have asked the Mayor of Waterbury for help and he is not interested in assisting us. He is more interested in giving corporate welfare in the form of property tax breaks than in securing a written agreement from the hospital with the community.

We need you to use your power to require a signed written community benefits agreement as a condition to receiving a Certificate of Need to purchase a non-profit

hospital. This is the type of direct accountability that we need to ensure the continued access to health care services for our patient population.

A few areas covered by our proposed community benefits agreement not ade□uately address in OCHA□s proposed final decision are:

- Maintain participation in Medicaid and Medicare for a minimum of 5 years and discuss continuing beyond that with the community
- Maintain hospital staffing according to state law
- Payment of local property taxes for the full amount of the Hospital□s value not just the e□uivalent of the current PILOT reimbursement
- Complete facility based financial transparency similar the IRS 990 form regarding finances, staffing and services and made publically available on the Waterbury Health Department website
- Continued dialogue with the broader community about services, □uality of care and other crucial issues

We believe that the government□s role is to help build a better future by promoting the general welfare. We believe that a signed community benefits agreement should be part of this policy. □eeping in mind our forbearers who contributed their hard earn money to build a hospital, we think a signed agreement with the community is not asking too much. Our community cannot take on a □9 billion corporation alone, you can make the difference.

We have an opportunity to create a community benefit □one where this healthcare corporation meets the needs of the community, creates and protects good jobs, provides □uality services, maintains justice on the job for the workers, contributes their fair share for public needs and complies with local state and federal laws.

We hope that you will join us in this effort

Sincerely,

Steve Schrag

Steve Schrag
Community United

Waterbury Hospital community benefits agreement

Section 1-There will be no change in service lines or locations such as behavioral mental health, cardiology, cancer services, diagnostic and imaging services, emergency department, family birthing and neonatal care, gastroenterology, infectious disease clinic, intensive critical care, outpatient medical therapies, primary care, pulmonary, rehabilitation, surgical and telemetry

Section 2-The Hospital will maintain current policies on charity care for a minimum of 5 years with the possibility of extending it based on future discussions with the community

Section 3-While Waterbury Hospital is owned by a Prospect affiliate it will provide charity care-under applicable law unless otherwise negotiated with the community

Section 4-The Hospital will accept Medicaid and Medicare for a minimum of 5 years with possibility of extending that based on future discussions with the community

Section 5-The Hospital will maintain staffing according to state law

Section 6-The Hospital will continue to have cultural and linguistic appropriate services available to patients

Section 7-The Hospital will hire employees under usual and customary hiring process and will work with the appropriate unions to ensure continuity and stability in the workforce

Section 8-There will be a local board created with additional advisory committees to solicit community ideas and input

Section 9-The Hospital will seek input for capital projects from the local board and advisory committee to help identify community needs

Section 10-The Hospital will seek input for capital projects from the local board and advisory committee to help identify community needs

There shall be ongoing dialogue and discussion with Community United and others to identify language and appropriate methods of accountability regarding the following concerns:

- Payment of property taxes for the full amount of the Hospital s value
- Conducting a Community health assessment as often and with the same effort that is re uired of non-profit hospitals
- Negotiation of a successor clause that will ensure that all sections of this agreement will last in perpetuity
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Greer, Leslie

From: Rosana Garcia <rgarcia@universalhealthct.org>
Sent: Friday, July 01, 2016 6:10 AM
To: User, OHCA
Cc: Lynne Ide; Adam Chiara; Tom Swan; stevenschrag@comcast.net
Subject: Public Comment on Proposed Final Decision GWHN & PMH (Docket 15-32017-486)
Attachments: Public Comment on Proposed Final Decision Waterbury Hospital & PMH 2016.pdf

To: Kimberly Martone, Director of Operations, Office of Health Care Access, Connecticut Department of Public Health
From: Rosana Garcia, Policy Associate, Universal Health Care Foundation of Connecticut
Date: July 1, 2016
Re: Public Comment on Proposed Final Decision GWHN & PMH (Docket 15-32017-486)

Ms. Martone,

Please see attached **Public Comment on Proposed Final Decision in Docket Number 15-32017-486** (Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.), submitted by Universal Health Care Foundation of Connecticut.

Please see below for the same copied inline.

Thank you for the opportunity to comment on this important matter.

Rosana Garcia

Rosana Garcia | **Policy Associate**
Universal Health Care Foundation of Connecticut
203.639.0550 ext. 314 | rgarcia@universalhealthct.org
290 Pratt Street, Meriden, CT 06450

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Public Comment on Proposed Final Decision in Docket Number 15-32017-486

(Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.)

Submitted by Universal Health Care Foundation of Connecticut

Contact Person: Rosana Garcia, Policy Associate

E: rgarcia@universalhealthct.org P: (203) 639-0550 ext. 314

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We applaud the Office of Health Care Access (OHCA) diligence in this matter, and many of the conditions OHCA has placed on this transfer of assets, which serve to ensure continued access for the community.

We do have some suggestions that will strengthen patient access, consumer protections, community engagement, and that will address community needs.

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We also suggest the addition of a condition that requires Prospect Medical Holdings, Inc., as a for-profit corporation, pay property taxes to the city of Waterbury, and any other towns where PMH will now hold property, with taxes being assessed on the full value of GWHN.

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Condition 6 (page 28) requires PMH to submit a plan that includes "any consolidation, reduction, or elimination of existing services or introduction of new services." We recommend that the community have the opportunity to read and weigh in on the "Services Plan," and that any proposed changes gain approval through Certificate of Need, including public notice and a public hearing.

We suggest that information that is reported to OHCA as set forth in Conditions 9, 12 and 13a, also be copied to the Office of the Health Care Advocate, and any other officials, such as state representatives and state senators of the "Service Area," and local public health departments. Any changes should have public notice, and the ability for the public to comment on the changes. Additionally, the information regarding PMH's community benefits and community building in relation to the CHNA, "Health Needs Study" and other objectives should be submitted annually after the Closing Date, rather than submitted for only three years after the Closing Date.

Condition 16 (page 3) stipulates the contracting of an Independent Monitor for a minimum period of 2 years. We recommend that rather than the option for the Independent Monitor to be extended one year, that there is the option for continued year-to-year extension if the Independent Monitor or OHCA become aware of non-compliance with the Conditions set forth in the final decision.

We suggest another condition that requires an independent multi-year evaluation of the hospital's service and financial performance over the first 5 years to determine whether converting back to non-profit status is an option to consider. PMH should be required to pay for this evaluation in its entirety, but must not have any hand in selecting the evaluator or in the design or conduct of the evaluation process. The evaluation should include authentic community engagement, and an assessment, by the community, of GWHN after PMH takes over ownership. An entity, such as the Connecticut Community Foundation or the Waterbury Campus of the University of Connecticut, should be asked to manage the evaluation process, to ensure an accurate, honest assessment of PMH's performance managing Waterbury Hospital and GWHN.

In Condition 19 (page 34), the twice annual "Joint Board Meetings" should not only include an opportunity for the public to ask "questions and make comments, but a requirement that PMH submit a written response to the public's "questions and comment. After the first three years, we recommend that these meetings occur at least annually.

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Generally, we strongly support and recommend any conditions on this transaction that keeps the community informed of any changes in GWHN and at Waterbury Hospital, and gives the public and community recourse for not only commenting on changes, but that a public hearing be conducted *before* any changes take place.

Ultimately, we want protections in place in light of historical events at Essent Sharon Hospital and Windham Community Memorial Hospital (WCMH). Despite conditions on the Sharon Hospital conversion, the community continues to struggle to be informed and engaged with changes at Sharon Hospital. WCMH's downgrade from running a Critical Care Unit (CCU) to a Progressive Care Unit (PCU) did not fall under the purview of the conditions set forth on that deal, nor Certificate of Need.

For this deal, we suggest that the community have the explicit right to be notified of changes, comment on any changes, including how it will affect patient access and quality of care in the community, and that a public hearing be conducted where the Waterbury Hospital and GWHN new leadership will have the opportunity to hear from the community directly, as well as respond to questions. We suggest that no major changes be made without explicit approval from OHCA, and that approval will solicit and take into account community input.

Again, we reiterate that Community United's request for a signed Community Benefits Agreement from PMH, should be a condition on this deal. The group should be commended for their civic involvement in this matter, and their input should be respected, discussed, and an agreement reached. Community United represents what the community wants from the deal and, no matter who runs Waterbury Hospital and GWHN, the hospital and its network should be ultimately accountable to the community it serves.

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Greer, Leslie

From: Lazarus, Steven
Sent: Monday, July 11, 2016 9:34 AM
To: Ann H. Zucker; Michele Volpe (mmv@bvmlaw.com)
Cc: Hawes, Gary W.; Turner, Cheryl A.; Hansted, Kevin; Martone, Kim; Riggott, Kaila; Greer, Leslie; Olejarz, Barbara
Subject: Emailing - 15-32017-486 and 15-486-02 _Close of Record.pdf
Attachments: 15-32017-486 and 15-486-02 _Close of Record.pdf

Dear Ann and Michele,

Please see the letter attached to this email, closing the record in the above referenced matter. If you have any question, please do not hesitate to contact Gary or myself.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

July 11, 2016

VIA ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Darlene Stromstad, President & CEO
Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Re: OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02 – Close of Record

Dear Mr. Spees and Ms. Stromstad:

The Office of the Attorney General ("OAG") and the Department of Public Health, Office of Health Care Access ("OHCA") hereby close their administrative records for the Application for Asset Purchase of Greater Waterbury Health Network, Inc. ("GWHN") by Prospect Medical Holdings, Inc. ("PMH") filed under OAG Docket No. 15-486-02 and OHCA Docket No. 15-32017-486. The record includes all Application materials submitted in response to the Application Form, the completeness questions, and the interrogatories issued by the OAG and OHCA. In addition, the record includes all written and oral testimony from the applicants and the written and oral statements of the public.

Should you have any questions regarding these dates, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General

Very truly yours,

Kevin Hansted
Hearing Officer, DPH/OHCA

cc: Steven Lazarus (via electronic mail)
Ann Zucker (via electronic mail)
Michele Volpe (via electronic mail)

Greer, Leslie

From: Greer, Leslie
Sent: Friday, July 15, 2016 11:29 AM
To: Ann H. Zucker (AZucker@carmodylaw.com); michelemvolpe@aol.com
Cc: Martone, Kim; Lazarus, Steven; Hawes, Gary W.; Riggott, Kaila; Cotto, Carmen; 'cheyl.turner@ct.gov'; Olejarz, Barbara; Downes, Maura
Subject: GWHN & Prospect Medical Holdings, Inc. CON Final Decision
Attachments: 32017_201607151128.pdf

Tracking:

Recipient	Delivery	Read
Ann H. Zucker (AZucker@carmodylaw.com)		
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Martone, Kim	Delivered: 7/15/2016 11:30 AM	
Lazarus, Steven	Delivered: 7/15/2016 11:30 AM	
Hawes, Gary W.	Delivered: 7/15/2016 11:29 AM	
Riggott, Kaila	Delivered: 7/15/2016 11:29 AM	
Cotto, Carmen	Delivered: 7/15/2016 11:29 AM	
'cheyl.turner@ct.gov'	Failed: 7/15/2016 11:29 AM	
Olejarz, Barbara	Delivered: 7/15/2016 11:30 AM	
Downes, Maura	Delivered: 7/15/2016 11:29 AM	Read: 7/15/2016 11:33 AM

Attached is the final decision for Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc.

Leslie M. Greer
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Final Decision

Applicants:	Greater Waterbury Health Network, Inc. 64 Robbins Street Waterbury, CT 06708 Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard Suite 400 Los Angeles, CA 90025
Docket Number:	15-32017-486
Project Title:	Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.

Procedural History: On July 16, 2015, the Applicants filed with the Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG") the Certificate of Need ("CON") Determination Letter proposing the transfer of assets of Greater Waterbury Health Network, Inc. and affiliates ("GWHN") to Prospect Medical Holdings, Inc. ("PMH"). The Applicants filed the application for the proposal on October 28, 2015. On March 4, 2016, OHCA and the OAG deemed the application complete.

On April 8, 2016, OHCA and the OAG notified the Applicants of the date, time and place of the public hearing. A notice to the public announcing the hearing was published in the *Republican American*. Thereafter, pursuant to Conn. Gen. Stat. §19a-639a and §19a-486, a public hearing regarding this application was held on May 3, 2016, jointly by OHCA and the OAG.

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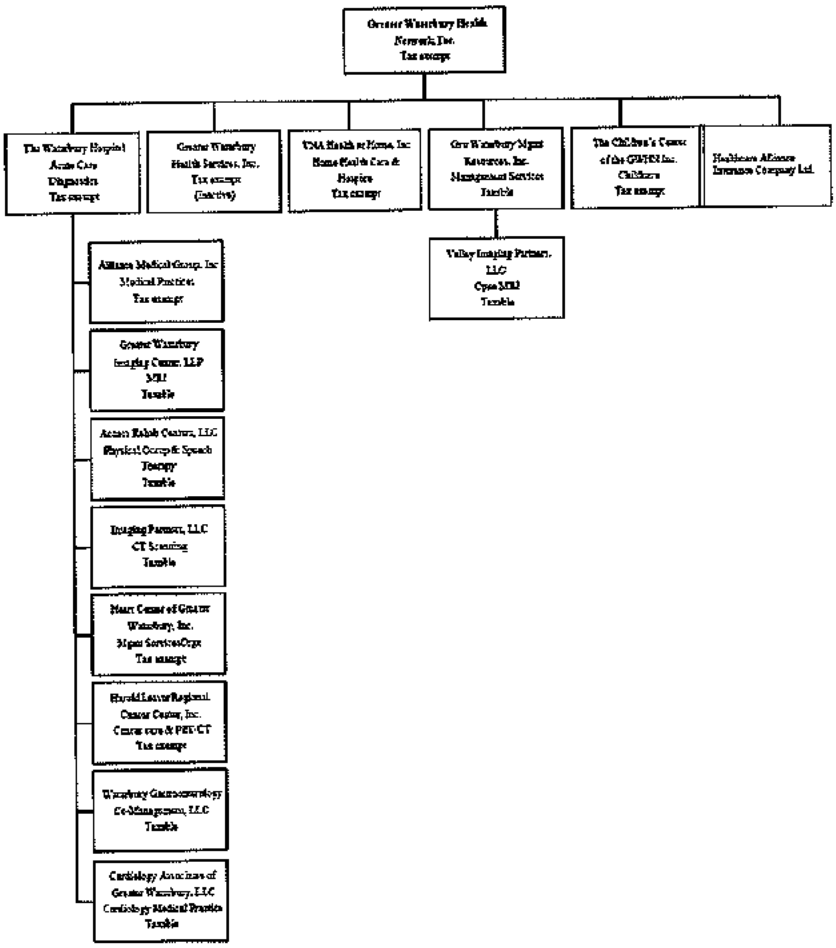
Attorney Kevin T. Hansted was designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedures Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. §19a-639a(f). The public hearing record was closed on July 11, 2016. Deputy Commissioner Brancifort reviewed the entire record in this matter, including the public comments received by OHCA after the issuance of the Proposed Final Decision.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc. v. S & H Computer Systems, Inc.*, 605 F. Supp. 816 (Md. Tenn. 1985).

Findings of Fact

1. GWHN is a non-stock, 501(c)(3) corporation that is the parent company to The Waterbury Hospital ("Hospital"), an acute care teaching hospital with 357 licensed beds plus 36 bassinets located in Waterbury, Connecticut. GWHN also holds interests in other entities, joint ventures, and affiliates. The chart below describes GWHN's current organizational structure:



Ex. E, p. 13

2. In addition to the Hospital, which is wholly owned by GWHN, GWHN is also an equity holder in the following entities: Healthcare Alliance Insurance Company, Ltd. ("HAIC," of which GWHN is a 50% owner), Greater Waterbury Health Services, Inc. ("GWHS," which is wholly-owned by GWHN), VNA Health at Home, Inc. (wholly-owned by GWHN), Greater Waterbury Management Resources, Inc. (wholly-owned by GWHN;

this company also has a 49% ownership in Valley Imaging, LLC), and Children's Center of Greater Waterbury Health Network, Inc. ("CCGWHN," which is wholly-owned by GWHN). Ex. E, pp. 15-16

3. The Hospital has ownership interests in the following entities: Alliance Medical Group, Inc. (wholly-owned by the Hospital), Greater Waterbury Imaging Center Limited Partnership (64% owned by the Hospital), Access Rehab Centers LLC (65% owned by the Hospital), Imaging Partners, LLC (85% owned by the Hospital), Waterbury Gastroenterological Co-Management Company, LLC (the Hospital is the sole Class H Member and has certain management rights), and Cardiology Associates of Greater Waterbury, LLC (wholly-owned by the Hospital). Ex. E, pp. 15-17

4. Additionally, the Hospital is a corporate member of two not-for-profit joint ventures with Saint Mary's Hospital ("SMH"): the Harold Leever Regional Cancer Center, Inc. and the Heart Center of Greater Waterbury, Inc. Ex. E, p. 17

5. The Hospital is GWHN's primary asset. It is a "safety net" hospital, treating a large number of Medicare, Medicaid and uninsured patients. Discharges for these three payers represent approximately 80% of the total patient days and 75.6% of emergency room outpatient visits. Ex. E, pp. 13, 15-16

6. The Hospital serves the following towns: Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury (the "Service Area"). Ex. E, p. 51

7. The Hospital has experienced consecutive years of losses due to poor economic conditions in the Service Area, declining government and commercial reimbursement, the increasing complexity of health care treatment, and national health care reform. Additionally the recession in 2008 led to GWHN defaulting on its bond covenants in 2009. In 2010, a consulting firm, Kaufman Hall, identified over $50 million in capital improvements required over five years to keep the Hospital operational. Ex. E, pp. 22-24, 333-434; Ex. R, Prefiled Testimony of Carl Contadini, Chairman of the Board, GWHN, p. 1509

8. In 2010, the Executive Committee of the GWHN Board of Directors (the "Board") recommended that the Hospital seek a capital partner and a task force was formed (the "Task Force"). Ex. E, p. 24

9. In 2011, the GWHN Board voted to authorize the negotiation of an agreement with LHP Hospital Group ("LHP") and SMH, but LHP ultimately terminated the proposed venture, citing the costs of building a replacement hospital and issues related to the Ethical and Religious Directives for Catholic Health Care Services. Ex. E, pp. 24-25

10. On September 4, 2012, the Board authorized the Task Force to pursue other opportunities, ultimately leading to the submission of proposals by Vanguard Health Systems, Inc. ("Vanguard") and PMH. PMH proposed an asset purchase transaction, while Vanguard proposed both an asset purchase transaction and a joint venture arrangement. Preferring a joint venture, GWHN pursued a relationship with Vanguard, and a Conversion Application and a CON Application were submitted. The OAG and OHCA issued decisions placing a number of conditions on the transaction, and Tenet Health Corporation (which had acquired Vanguard) withdrew the application. Ex. E, pp. 25-26, 29-30, 88-119

11. In early 2015, the Task Force requested that Cain Brothers, an investment advisory firm, look for new prospective partners. PMH was one of two candidates to indicate interest and, despite GWHN's declining financial performance, agreed to a deal similar to the proposed Tenet transaction. The Task Force approved PMH's proposed letter of intent and the Board authorized its execution, which occurred on May 1, 2015. After conducting due diligence, the Board adopted resolutions approving the transaction and the filing of the CON, as well as recommending to the various members of GWHN that they approve the transaction. On October 2, 2015, the GWHN members approved the transaction and authorized the Board to take all action to consummate the transaction. Ex. E, pp. 31-33, 88-119

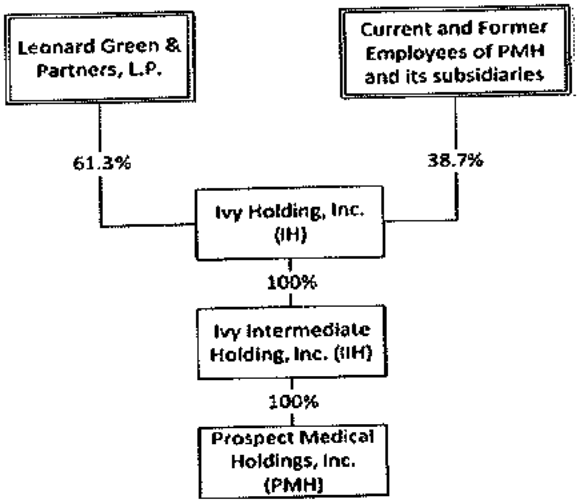
12. The Applicants are requesting approval of the proposed asset purchase (the "Asset Purchase") as a solution to GWHN's long-standing challenges that offers the Service Area continued access to its services and facilities. Ex. R, Prefiled Testimony of Carl Contadini, p. 1510

13. PMH is a for-profit, privately owned national healthcare services company with its principal place of business in Los Angeles, California. PMH owns fourteen acute care and behavioral hospitals in California, New Jersey, Rhode Island and Texas. It also owns a network of specialty and primary care clinics in each of these regions. Ex. E, pp. 18, 171-72

14. Through PMH's medical group segment, PMH also manages the provision of physician services in each of its markets through a network of approximately 8,900 physicians. The physician networks operate as independent practice associations ("IPAs") that contract with PMH-owned management service organizations ("MSOs"). The IPAs are comprised of both PMH-employed and independent community physicians. Ex. E, p. 18; Ex. R, Prefiled Testimony of Mitchell Lew, President, PMH, pp. 1605, 1607-08; Testimony of Mitchell Lew on 5/3/2016, pp. 37-38

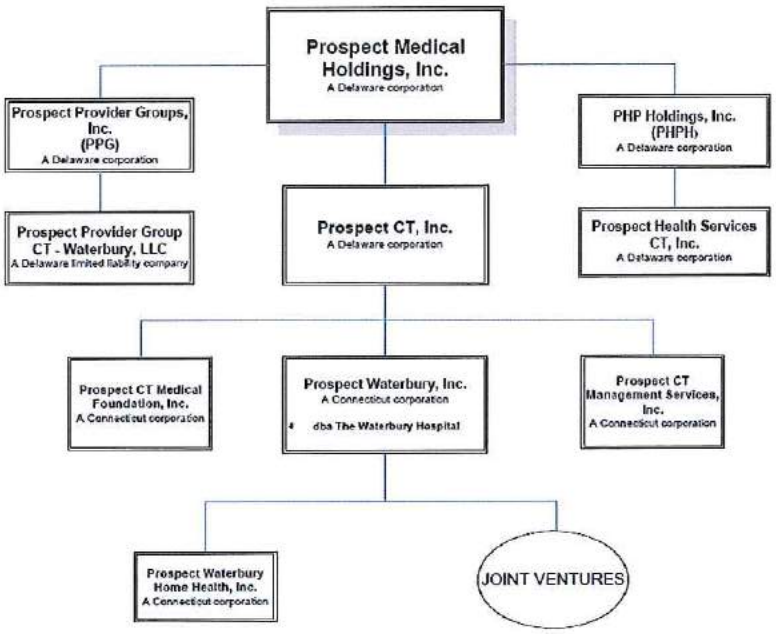
15. PMH aligns its hospitals and physicians under a model called Coordinated Regional Care ("CRC"). CRC provides for clinical integration of hospitals, physicians and community providers with health plans and other payers through value driven and risk-based reimbursement systems. PMH believes that the CRC model improves quality, efficiency and financial performance while providing its patients with quality, affordable healthcare. Ex. E, pp. 89

16. The chart below shows PMH's current ownership structure:



Ex. H, p. 1413

17. The chart below shows PMH's proposed organizational structure below the holding company level after the proposed transaction:



Ex. E, p. 68

18. GWHN selected PMH as the proposed purchaser because its financial resources and access to capital are anticipated to maintain GWHN's assets as economically viable and vibrant parts of the healthcare system in the Service Area by permitting capital investments, better preparing the Hospital to participate in new value-based delivery models, offering enhanced practice options for physicians, strengthening its network of providers and allowing for other improvements in operations. Ex. R, Prefiled Testimony of Mitchell Lew, p. 1606; of Ex. R, Prefiled Testimony of Darlene Stromstad, President & CEO, GWHN, pp. 1516-20; Ex. R, Prefiled Testimony of Von Crockett, Senior Vice President of Corporate Development, PMH, pp. 1537-39

19. In its audited financial statements for FY 2015, PMH reported total revenues of over $1.3 billion from its operations on a consolidated basis. As of fiscal year end 2015, PMH reported free cash flow of over $112 million and close to $75 million in cash from operations. The company also received credit upgrades by both Moody's and S&P in 2015, with Moody's rating PMH's bonds as B1 and S&P rating PMH's bonds as B. These ratings still stand as of May 3, 2016. Ex. R, Prefiled Testimony of Steven Aleman, Chief Financial Officer, PMH, p. 1620; Testimony of Steven Aleman, Tr. on 5/3/2016, p. 113; Docket#15-32016-486, Ex. N, pp. 3245, 3249-59; Ex. K, pp. 1445-46

20. Under the proposed Asset Purchase Agreement ("APA"), PMH will pay a total purchase price of approximately $43.3 million for the assets of GWHN, which includes a purchase price of $31.8 million plus a net working capital adjustment of $18.3 million, as of April 30, 2016, minus capital lease obligations in excess of $6.5 million, unfunded pension liabilities, asbestos abatement liability, the amounts of certain GWHN liabilities assumed by PMH, and for the value of any joint venture interest that GWHN is unable to assign or transfer. Ex. E, pp. 12, 20, 71, 147; Ex. F, p.1419; Late File 3, pp. 1848-49

21. PMH will commit to spend within seven years no less than $55 million, less (a) the amount not to exceed $3.5 million of capital lease obligations assumed by PMH at Closing in excess of $3 million, (b) the cash shortfall at closing (defined in the APA as the "Negative Amount"), (c) the Purchase Price Adjustment Shortfall, provided that the aggregate of the amounts in (b) and (c) are not to exceed $5.0 million in aggregate, and (d) unpaid indemnification losses of PMH (defined in the APA as the "Unpaid Losses") of up to $4.5 million, (the "Commitment Amount"). (Revised APA draft dated June 10, 2016, pages 1861and 1977).

22. There is no financing contingency with respect to this transaction. PMH anticipates funding this acquisition using its existing cash. PMH also has access to a preapproved $40 million revolving line of credit with Morgan Stanley and, as shown below, PMH has provided data showing that its debt leverage ratio is lower than other for-profit hospital systems.

Industry Debt Leverage Ratio Comparison	
Entity	**Ratio**
Prospect	2.71X
Hospital Corporation of America	3.7X
Community Health Systems	5.4X
Tenet	6.3X

Ex. R, Prefiled Testimony of Steven Aleman, p. 1621; Ex. E, p. 69, Ex, K, p.1445; Docket#15-32016-486, Ex. K, p. 2191

23. Closing the transaction is estimated to require only $27 million in cash from PMH. By the closing date (the "Closing" or "Closing Date"), PMH anticipates it will have close to $100 million in cash on hand as a result of its growth in revenues, which are generating $10-15 million of free cash flow on a monthly basis. The $40 million revolving line of credit, which PMH recently drew down to $10 million to finance its purchase of East Orange General Hospital in New Jersey, is also expected to be restored to $30 million by the Closing. Ex. F, p. 1419; Late File 3, p. 1849; Testimony of Steven Aleman, Tr. on 3/29/16, pp. 151-53

24. The following GWHN assets will be excluded from the transaction:

- All cash and cash equivalents;
- All short-term and long-term investments other than GWHN's investments in the joint ventures;
- Board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, working capital trust assets, and assets and investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;
- Prepaid expenses not assumed by PMH;
- All insurance proceeds arising in connection with the operation of the assets or the facilities for periods prior to Closing to the extent that all damage to the assets has been repaired;
- All amounts due or to become due to GWHN from the Medicare, Medicaid or other payor programs in respect of cost report periods ended on or prior to Closing; and
- Interests in and assets of GWHS, CCGWHN and HAIC.

Ex. E, pp. 19, 142

25. GWHN's debt and pension obligations will also be addressed as a result of the transaction. At the time of the Closing and as permitted thereafter, the purchase price (less adjustments) together with GWHN's cash, investments and debt service reserve funds (but excluding charitable funds) will be used to satisfy GWHN's obligations. GWHN's unfunded pension liabilities with respect to its multi-employer defined benefit health plan are estimated to be at least $27 million and, with respect to its cash balance plan, are approximately $12 million. Ex. F, pp. 76, 1419; Prefiled Testimony, Steven Aleman, p. 1620

26. Table 1 summarizes the net proceeds and flow of funds associated with the Asset Purchase as of April 30, 2016 compared to September 30, 2015, including GWHN's anticipated plan for payment of debt and pension obligations as well as payment of other liabilities. The amounts are subject to adjustment at Closing.

TABLE 1
APA PROJECTED NET PROCEEDS AND FLOW OF FUNDS

Proceeds Calculation	As of 9/30/2015	As of 4/30/2016*
Proceeds		
Enterprise Value	$31,800,000	$25,000,000
Working Capital Adjustment	$4,601,512	$18,258,911
Total Gross Proceeds	**$36,401,512**	**$43,258,911**

PM Assumed Liabilities		
Asbestos Abatement	($2,896,529)	($2,898,529)
Nurses Pension	($27,000,000)	($27,000,000)
Hospital Cash Balance Plan	($11,613,917)	($12,363,507)
Total Assumed Liabilities	**($41,512,446)**	**($42,262,036)**
Net Proceeds	**($5,110,934)**	**($996,875)**
Unrestricted Cash	$35,767,106	$35,174,646
Total Unrestricted Cash and Net Proceeds	**$30,656,172**	**$36,171,521**
Cash Needs at Closing		
Estimated Transaction Costs	($1,450,000)	($1,450,000)
Bank Debt	($24,094,638)	($23,783,297)
Debt Swap	($1,512,596)	($1,851,544)
Total Cash Needs at Closing	**($27,057,234)**	**($27,084,841)**
Net Cash Post Closing Liabilities & Expenses	**$3,598,937**	**$9,086,680**

*All figures are current through April 30, 2016, with the exception of the Children's Center, which is current through March 31, 2016.
Ex. E. pp 1419 and Ex. AA, Late File 3.

27. After Closing, the assets of GWHN will be transferred to Prospect Connecticut, Inc. ("New GWHN") or one or more of its affiliates. New GWHN will serve as the health system parent company and sole shareholder of Prospect Waterbury, Inc., which will hold the Hospital's license after Closing (the post-closing hospital will be referred to as "New Hospital"). Ex. E, p. 21

28. The Commitment Amount will be funded through GWHN's operating income, and any shortfall will be funded by PMH's existing cash or through PMH's corporate level credit facility. Ex. E, p. 69

29. The Commitment Amount will be dedicated to continued improvement in quality and safety, expansion of services, new services, physician and service integration, and improvements in access to service. Ex. E, p. 57

30. PMH does not currently plan to change any service lines or locations as a result of the Asset Purchase. Ex. E, p. 48

31. There is currently no capital plan related to the transaction. After Closing, PMH, in consultation with the Local Board (defined in paragraph 38 below), will develop a strategic capital plan with respect to the New Hospital and associated affiliates and joint ventures. Ex. E, p.70; Ex. R., p. 1641

32. The capital projects in Table 2 below have been identified by GWHN management as priority capital projects to be addressed within the first three years after Closing. Ex. E, p. 72

TABLE 2
CAPITAL PRIORITY PROJECTS IDENTIFIED BY GWHN

Description	Estimated Cost (In Millions)	Estimated Timeframe (In Months)
Facility – Main Campus		
Expansion of ED/Development of urgent care*	$3.75	24-36
Upgrade OB/Women's health	$2.0	6-18
Upgrade outpatient surgery**	$2.0	6-18
Equipment		
Replace interventional radiology equipment	$1.7	12-18
Upgrade surgical/anesthesia equipment	$1.5	12-18
Outpatient Centers (Southbury, Naugatuck and Waterbury)* **	N/A	N/A
Physician Recruitment	N/A	N/A
Information Technology		
Continue IT Plan	N/A	N/A
Implement outpatient/physician practice strategy	N/A	N/A
Patient Safety****	$3.24	12-36
Total Estimated Cost	**$14.2**	

No dollars have yet been assigned to outpatient centers, physician recruitment and information technology.

* The Hospital's emergency department was built to accommodate 35,000 patients annually, while actual utilization is about 50,000, resulting in lengthy patient wait times and higher than average "Left Without Being Seen" rates. Additionally, hallways are consistently used as patient rooms. Expanding the emergency department will improve access to care, decrease LWOS, and improve patient privacy. Ex. Ex. H, pp. 1416-17

** There is no separate area for outpatient surgery. Accordingly, patients are currently being redirected to outpatient surgery centers in the community. Ex. H, p. 1417

*** The Hospital currently provides several health care services in Southbury, Naugatuck, and Waterbury. PMH intends to co-locate services by developing outpatient centers in each of these towns, creating a central environment with adequate parking and convenient access for patients. Ex. H, p. 1417

**** Immediate capital needs required over the first two to three years following Closing are: monitors in the ER ($600,000), ER architects/plan ($200,000), nuclear med ($450,000), fetal monitors ($145,000), EKG ($550,000), defibrillators ($240,000), two Jackson tables ($200,000), nurse call/ED ($220,000), bed replacements ($360,000), med cart replacements ($150,000), and beginning anesthesia update ($120,000). Ex. R, p. 1640

33. Because of GWHN's poor financial condition, the projects identified in Table 2 cannot be accomplished without this transaction. Ex. R., Prefiled Testimony of Carl Contadini, p. 1510; Testimony of Darlene Stromstrad, Tr. on 5/3/2016, p. 30; Ex. R, Prefiled Testimony, Jonathan Spees, Vice President of Mergers and Acquisitions, PMH, pp. 1626-27

34. With the proposed Asset Purchase, the parties expect that PMH will provide sufficient capital to meet deferred, current and future capital needs for the Hospital's physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology. With PMH's access to capital, New Hospital will have the financial resources to purchase new technology, upgrade its facilities, attract skilled providers, and upgrade electronic health records, in addition to investing in service line development, physician alignment and recruitment and development of increasing ambulatory access. Ex. R, Prefiled Testimony, Jonathan Spees, p. 1627

35. Table 3 below represents GWHN's projected incremental operating revenues, earnings before interest, taxes, depreciation and amortization (EBITDA) and gain/losses from operations and provisions for income taxes with this proposal.

TABLE 3
GWHN PROJECTED INCREMENTAL OPERATING REVENUE, EBITDA, INCOME FROM OPERATIONS, AND PROVISION FOR INCOME TAXES WITH THE PROPOSAL

	FY 2016	FY 2017	FY 2018
Operating Revenue	$324,151	$3,702,750	$6,827,192
Earnings Before Interest, Taxes, Depreciation & Amortization (EBITDA)	$1,408,798	$3,620,294	$4,425,395
Gain/Loss from Operations	$962,989	$1,868,015	$2,256,121
Provision for Income Taxes	$785,217	$2,172,366	$2,050,340

Ex. E, p.1167

36. PMH has restored the financial position of other health systems by applying its data-driven operating strategies, leveraging its corporate capabilities and investing in system growth. Ex. R, Prefiled Testimony, Jonathan Spees, p. 1627

37. Table 4 below illustrates the financial performance of the Texas and Rhode Island hospitals after they were acquired by PMH:

TABLE 4
PMH'S RECENT ACQUISITIONS FINANCIAL PERFORMANCE (in Thousands)

Entity	EBITDA			Working Capital			Stockholder's Equity		
	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015
Nix Health System (a)	$14,905	$18,411	$8,043	$5,937	$36,785	$35,449	$13,122	$20,468	$63,789
Roger Williams Medical Center (b)	$3,942	$1,582	$9,080	($1,860)	$1,114	$6,230	$37,184	$34,099	$38,256
Our Lady of Fatima Hospital(c)	($893)	$509	$6,485	$1,904	$2,040	$3,432	($57,150)	$27,513	$28,107

(a) Nix is a Health System based in Texas. Nix's Earnings Before Interest, Taxes, Depreciation and amortization (EBITDA) is based on reported trailing twelve months ended on 1/31/2011. Declines in EBITDA between 2014 and 2015 were due to the fluctuation in net reimbursement related to payments made to the Service Organization of San Antonio "SOSA". Funding to SOSA is voluntary but it is projected to average approximately $12M a year based on budgeted spending initiatives of the service organization. In 2014 the funding requirements were $5.7M (lower by approximately $6.3M) and in 2015 funding requirements returned to $12M. The remaining difference was comprised of lower volume at the facility as services were reconfigured and medical staff turnover. Working Capital of Nix prior to acquisition is as of 1/31/2011 and includes cash which was not part of assets acquired by PMH.

(b) EBITDA for Roger Williams Medical Center ("RWMC"), located in Providence , Rhode Island, for year prior to acquisition is only for 8 months ending on May 31, 2014 and EBITDA for FY2014 is only for three months post acquisition for FYE 9/30/2014. Working capital is for prior to acquisition as of 5/31/2014 and includes cash which was not part of the assets acquired by PMH as prior to the acquisition RWMC was a non-profit organization. Therefore, net assets were used as a substitute for stockholder's equity.

(c) EBITDA for Our Lady of Fatima Hospital ("OLFH") in Rhode Island is for year prior to acquisition and is only for 8 months ending on May 31, 2014 and for FY2014 is only for three months post acquisition. Working capital prior to acquisition is as of 5/31/2014 and includes cash which was not part of the assets acquired by PMH as prior to the acquisition OLFH was a non-profit organization. Therefore, net assets were used as a substitute for stockholder's equity.

Docket#15-32016-486, Late File 19, dated Apr. 20, 2016; Docket#15-32016-486, Ex. QQ, dated May 9, 2016

38. After Closing, the New Hospital will be governed by a board of directors controlled by PMH (the "New Hospital Board"). The New Hospital Board will have oversight and ultimate authority over the affairs of the New Hospital and the purchased assets. The New Hospital Board will be composed of executives of PMH and local employed executives of GWHN. There are currently no actual or proposed bylaws for the New Hospital Board. Ex. E, p. 20; Ex. H, p. 1422

39. The New Hospital Board will be advised by a local advisory board, anticipated to be comprised of five current members of the GWHN Board, five physicians, and the CEO of the New Hospital (the "Local Board"). The Local Board will serve as a resource for PMH with respect to development and review of strategic plans, assist with maintenance and implementation of a strategic business plan for the New Hospital, and assist with medical staff credentialing, quality assurance programs and accreditation at the New Hospital. There are currently no actual or proposed Bylaws for the Local Board. Ex. E, pp. 20-21, 190; Ex. H, pp. 1422-23

40. As of the Closing Date, PMH or an affiliate will offer employment to substantially all GWHN employees who are in good standing, in positions and at salaries at least equal to those then being provided by GWHN and with benefits packages comparable to those offered to similarly-situated employees at other hospitals operated by PMH. Ex. E, pp. 86, 90, 176

41. PMH plans to establish a strong physician network by recruiting high quality physicians to GWHN's medical staff. PMH has developed significant experience in other markets regarding methods of attracting more primary care providers and improving access to care. Recently, PMH succeeded in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners participating in PMH's Rhode Island physician network at the end of 2015, only 18 were employed by the CharterCare System when PMH acquired its two hospitals (RWMC and OLFH) in mid-2014. Ex. E, p. 89; Docket#15-32016-486, Ex. G, p. 75; Ex. K, p. 2177-78

42. In order to implement the CRC strategy, PMH has established an IPA entity in Connecticut (Prospect Provider Group CT-Waterbury, LLC, or "PPGCTW") and a preferred provider network/health system risk taking entity, Prospect Health Services CT, Inc., that will contract with payers on behalf of PPGCTW physicians. These two organizations, through management services agreements with PMH, will manage physician participation, risk contracting and care management activities for participating members. Ex. E, p. 87; Ex. H, p. 1430; Ex. R, Prefiled Testimony of Mitchell Lew, p. 1605; Testimony of Mitchell Lew, Tr. on 5/3/2016, pp. 37-38

43. The goal of the CRC model is to reduce the overall cost of health care by increasing preventive care and reducing readmissions, inpatient utilization and emergency room visits. PMH will achieve these goals by developing a healthcare delivery network encompassing the entire continuum of patient care, including inpatient services, home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health related services. Ex. E, pp. 62, 89; Ex. R, Prefiled Testimony of Mitchell Lew, pp. 1607, 1609, 1611-12

44. PMH has demonstrated the efficacy of the CRC model in Southern California, Texas and Rhode Island. In these regions, PMH has improved clinical outcomes, increased quality scores, increased patient satisfaction, reduced readmission rates, reduced average lengths of stay, and reduced medical-cost ratios. For example, from 2012 to 2014 in California and Texas, where PMH participates in HMO contracts for seniors, PMH reduced hospital bed days per thousand patients from 1,260 to 720. Additionally, length of hospital stay for this population has been reduced from 5.1 to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. The CRC model has also enabled PMH to attract more primary care providers and has improved access to care. Ex. E, p. 65-66; Ex. R, Prefiled Testimony of Mitchell Lew, pp. 1608, 1610, 1615

45. PMH has agreed to adhere to GWHN's charity care policies for at least the first five years after Closing. For the first five years, PMH has also agreed to participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, provide public health programs of educational benefit to the community, and to generally promote public health, wellness, and welfare to the community by operating the New Hospital with quality standards consistent with other hospitals owned by PMH. Ex. E, pp. 61-63, 81, 1226-28; Ex. H, p. 1437; Testimony of Von Crockett, Tr. on 5/3/2016, p. 98; Tr., Testimony of Tom Reardon, President, PMH East on 5/3/16, pp. 103-04

46. PMH will continue to provide financial support for community benefit and community building activities in the Waterbury area to the same degree as GWHN did in FY 2014. The spending by PMH for community building activities post-closing is projected to increase 1% each year through FY 2019, and the spending for both community benefit and community building activities post-closing assumes no change in the Medicaid population served or the complement of community benefit programs offered by the New Hospital. Ex. E, pp. 83-84; Testimony of Jonathon Spees, Tr. on 5/3/2016, p. 104

47. Table 5 below describes the socioeconomic condition of the Service Area towns in comparison to the state of Connecticut as a whole and shows the areas most in need of such programs.

TABLE 5
SOCIOECONOMIC STATUS OF THE SERVICE AREA

Data				
Town	Poverty Rate	Medium Household Income	Unemployment Rate	Medium Age
Primary Service Area				
Beacon Falls	3.8%	$ 79,207	7.0%	39
Bethlehem	4.4%	$ 80,884	5.8%	50
Cheshire	2.8%	$ 110,587	6.2%	41
Middlebury	2.6%	$ 97,996	5.9%	45
Naugatuck	8.6%	$ 62,574	9.4%	39
Prospect	3.2%	$ 95,325	6.7%	44
Southbury	6.4%	$ 67,195	6.6%	50
Thomaston	2.7%	$ 67,426	7.8%	43
Waterbury	21.9%	$ 40,867	12.5%	35
Watertown	3.4%	$ 80,899	7.7%	44
Wolcott	3.4%	$ 80,655	7.8%	44
Woodbury	4.6%	$ 80,167	5.9%	48
Secondary Service Area				
Harwinton	4.6%	$ 89,429	6.1%	47
Morris	5.6%	$ 89,688	6.4%	45
Oxford	4.5%	$ 107,308	6.0%	43
Plymouth	6.7%	$ 73,603	8.9%	41
Seymour	6.8%	$ 73,099	7.7%	42

Southington	3.6%	$ 78,668	6.4%	44
Torrington	11.2%	$ 50,548	8.5%	43
State	**10.0%**	**$ 69,519**	**7.8%**	**40**

Ex. E, p. 54

48. Central Waterbury is designated as a Medically Underserved Area and a Health Professionals Shortage Area. The Hospital currently provides safety net services in this area. The Applicants anticipate that the proposed Asset Purchase will support the availability of health care services to vulnerable populations in the Service Area. Ex. E, p. 54

49. In 2013, the Hospital conducted a Community Health Needs Assessment ("CHNA"), which identified current and future health care needs of the community. The priority areas identified for the greater Waterbury community were access to care, mental health/substance abuse, overweight/obesity, and smoking/tobacco use. An implementation plan was developed to respond to the identified health needs, which PMH has agreed to support. Additionally, the Hospital has traditionally taken a lead role in developing the CHNA, and PMH has agreed to maintain GWHN's current level of involvement in developing and implementing the CHNA for five years from Closing. Ex. E, pp. 60, 62, 1075-1129, 1130-49; Ex. H, p. 1439; Testimony of Von Crockett, Tr. on 5/3/2016, pp. 90-91

50. PMH has also stated that the New Hospital will be in compliance with the following general community benefit standards for at least the first three years after the Closing: (a) the New Hospital will have an open medical staff and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors and (b) the New Hospital will operate a 24/7 emergency department and provide emergency services to patients regardless of their ability to pay. Testimony of Tom Reardon, Tr. on 5/3/16, pp. 103-04

51. PMH and GWHN representatives have already met with leadership for Connecticut's Medicaid Program at the Department of Social Services ("DSS") and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. PMH is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state. In addition, PMH will actively work with other providers in the community such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the Service Area, including Medicaid recipients. Ex. E, pp. 63-65

52. The patient population currently served by the Hospital is not expected to change as a result of the Asset Purchase. PMH will accept all existing contracts with payers and will complete a change of ownership process with commercial payers, as well as Medicare and the Connecticut Medical Assistance Program (Medicaid). Table 6 below describes the current and projected patient population and payer mix for the Hospital with respect to discharges.

TABLE 6
PATIENT POPULATION/PAYER MIX

Hospital	YTD 8/31/15	Projected 2015	Projected FY 2016	Project FY 2017	Projected FY 2018
Medicare	5,002	5,457	5,312	5,312	5,312
Medicaid	3,021	3,296	3,196	3,196	3,196
CHAMPUS or TriCare	18	19	18	18	18
Total Government Payers	8,041	8,771	8,526	8,526	8,526
Commercial Insurers	2,527	2,757	2,681	2,681	2,681
Self-Pay	113	123	64	64	64
Workers Compensation	61	67	73	73	73
Total Non-Government Payers	2,701	2,947	2,818	2,818	2,818
Total Payer Mix	**10,742**	**11,718**	**11,344**	**11,344**	**11,344**

Ex. E, pp. 74, 76

53. Financial benefits associated with this proposal include: operational efficiencies and economies of scale, the New Hospital's participation in PMH's purchasing power, supply chain benefits, employee benefits savings and streamlined revenue collection. PMH also makes available to its hospitals subject matter consultants who are employed by PMH, saving its hospitals the cost of hiring consultants in those areas. Ex. R, Prefiled Testimony of Von Crockett, p. 1535; Docket#15-32016-486, Ex. N., p. 3236

54. PMH has agreed to maintain GWHN's quality program for at least two years following the transaction. Ex. T, p. 1826; Ex. R., Prefiled Testimony of Von Crockett, p. 1533

55. PMH has had to significantly modify its own Quality Assurance and Performance Improvement ("QAPI") as a result of recent surveys of two PMH hospitals in California, Los Angeles Community Hospital and Southern California Hospital, resulting in the California Department of Health imposing Immediate Jeopardy citations. Ex. K, p. 1459-61; Ex. R, Prefiled Testimony of Von Crockett, pp. 1530-33

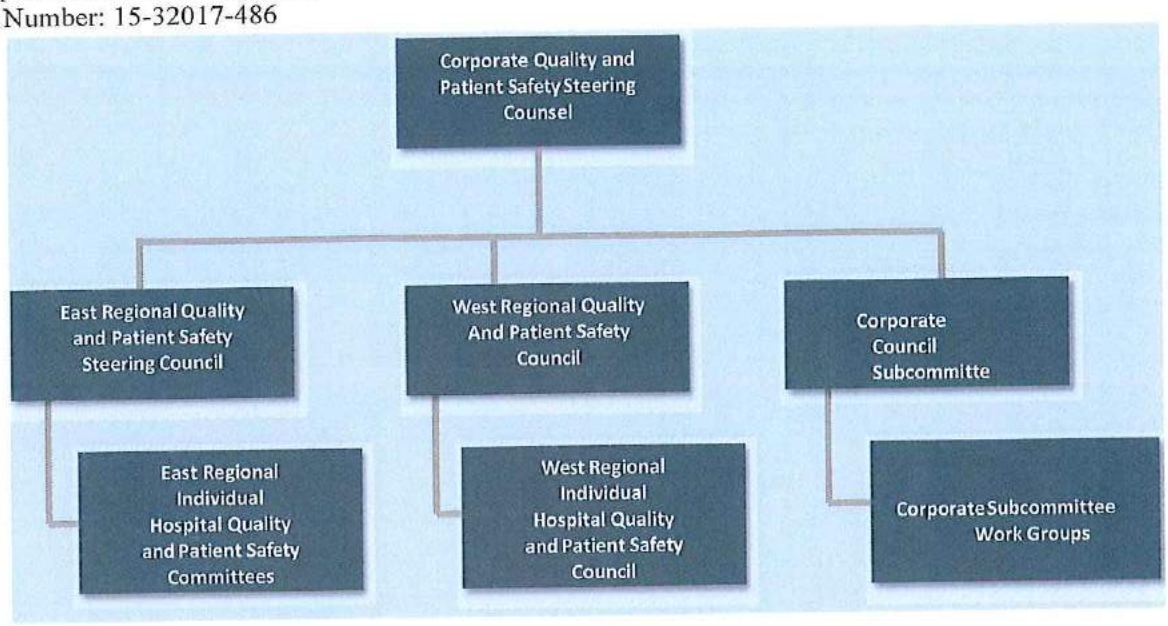
56. GWHN representatives learned of the Immediate Jeopardy citations on February 11, 2016. In response, the GWHN Board appointed a task force to review the citations and corrective actions taken and to recommend whether or not to proceed with the transaction. The task force reviewed the deficiencies and corrective action plans, conducted interviews, and made site visits to PMH-owned hospitals in both California and Rhode Island. The task force determined that PMH was committed to quality and proposed that GWHN obtain certain assurances from PMH and move forward with the transaction. Ex. R, pp. 1635-36; Testimony, Susan Cordeau, Director of Performance Improvement, GWHN, Tr. on 5/3/2016, pp. 25-31

57. Accordingly, on April 27, 2016 the parties entered into a Quality Assurance Commitment Letter pursuant to which PMH agreed to maintain certain GWHN quality programs for the first two years after the Closing Date and to not modify them without approval of the Local Board. The Quality Assurance Commitment Letter also requires that PMH maintain QAPI programs consistent with best practices and those currently implemented in PMH's Rhode Island facilities while also acknowledging that the Local Board shall oversee quality programs at the New Hospital. Ex. T, p. 1826

58. Based on the information learned and protections gained, the task force recommended, and the Board confirmed, GWHN's commitment to proceed with the transaction. Ex. R, pp. 1635-36; Testimony, Susan Cordeau, Tr. on 5/3/2016, pp. 30-31

59. Additionally, as a result of the Immediate Jeopardy citations, PMH has hired a corporate level Chief Quality Officer, Chief Clinical Officer, Chief Nursing Officer and an Associate Vice President of Regulatory and Patient Safety to assist in providing necessary resources to implement all quality programs at its local hospitals and share best practices among the hospitals. Ex. K, p. 1459; Ex. R, Prefiled Testimony of Von Crockett, pp. 1530-32

60. Other PMH initiatives include retaining a national consulting firm and legal counsel to assist in preparedness and responses to Centers for Medicare and Medicaid Services ("CMS") surveys. Under PMH's draft QAPI program, a Hospital Quality & Patient Safety Committee will be developed at the New Hospital, with oversight over subcommittees and workgroups that address the New Hospital's unique needs. These committees will report to a Regional Quality and Patient Safety Steering Council, which will report to the Corporate Quality and Patient Safety Steering Council, as described below:



Testimony of Debbie Berry, Chief Quality Officer, PMH, pp. 57-59; Ex. R, pp. 1692, 1696; Docket#15-32016-486, Tr., Testimony of Von Crockett on 3/29/15, pp. 93-94; Docket#15-32016-486, Ex. Z, Prefiled Testimony of Von Crockett, pp. 3356-57; Docket#15-32016-486, Ex. Z, pp. 3402-03; Docket#15-32016-486, Late File 1, dated Apr. 20, 2016; Docket#15-32016-486, Late File 10, dated Apr. 20, 2016

61. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. Conn. Gen. Stat. § 19a-639(a)(1)

62. The application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. Conn. Gen. Stat. § 19a-639(a)(2)

63. The Applicants have established that there is a clear public need for the proposal. Conn. Gen. Stat. §19a-639(a)(3)

64. The Applicants have demonstrated that the proposal will improve the overall financial strength of the health care system and that it is financially feasible. Conn. Gen. Stat. §19a-639(a)(4)

65. Subject to the conditions below, the Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. Conn. Gen. Stat. §19a-639(a)(5)

66. Subject to the conditions below, the Applicants have shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. Conn. Gen. Stat. §19a-639(a)(6)

67. The Applicants have satisfactorily identified the population to be affected by this proposal. Conn. Gen. Stat. §19a-639(a)(7)

68. The historical utilization of GWHN's services in the Service Area support this proposal. Conn. Gen. Stat. §19a-639(a)(8)

69. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. Conn. Gen. Stat. §19a-639(a)(9)

70. Subject to the conditions below, the Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. Conn. Gen. Stat. §19a-639(a)(10)

71. The Applicants have satisfactorily demonstrated that the proposal will not have a negative impact on the diversity of health care providers in the area. Conn. Gen. Stat. §19a-639(a)(11)

72. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. Conn. Gen. Stat. §19a-639(a)(12)

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 considered the factors set forth in Connecticut General Statutes § 19a-639(a) and 19a-486d. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board,* 309 Conn. 727 (2013).

GWHN is a non-stock, 501(c)(3) corporation that is the parent company to The Waterbury Hospital ("Hospital"), an acute care teaching hospital with 357 licensed beds plus 36 bassinets located in Waterbury, Connecticut. GWHN also holds interests in other entities, joint ventures, and affiliates. *FF1* GWHN serves the following towns: Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott, and Woodbury. *FF6* PMH is a for-profit, privately owned national healthcare services company with its principal place of business in Los Angeles, California. PMH owns fourteen acute care and behavioral hospitals in California, New Jersey, Rhode Island and Texas. It also owns a network of specialty and primary care clinics in each of these regions. *FF13* The Hospital has experienced consecutive years of losses due to poor economic conditions in the Service Area, declining government and commercial reimbursement, the increasing complexity of health care treatment, and national health care reform. Additionally the recession in 2008 led to GWHN defaulting on its bond covenants in 2009. In 2010, a consulting firm, Kaufman Hall, identified over $50 million in capital improvements required over five years to keep the Hospital operational. *FF7* The Applicants are requesting approval of the proposed asset purchase (the "Asset Purchase") as a solution to GWHN's long-standing challenges that offers the Service Area continued access to its services and facilities. *FF12*

Under the proposed Asset Purchase Agreement ("APA"), PMH will pay a total purchase price of approximately $43.3 million for the assets of GWHN, which includes a purchase price of $31.8 million plus a net working capital adjustment of $18.3 million, as of April 30, 2016, minus capital lease obligations in excess of $6.5 million, unfunded pension liabilities, asbestos abatement liability, the amounts of certain GWHN liabilities assumed by PMH, and for the value of any joint venture interest that GWHN is unable to assign or transfer. *FF20* PMH will commit to spend within seven years no less than $55 million, less (a) the amount not to exceed $3.5 million of capital lease obligations assumed by PMH at Closing in excess of $3 million, (b) the cash shortfall at closing (defined in the APA as the "Negative Amount"), (c) the Purchase Price Adjustment Shortfall, provided that the aggregate of the amounts in (b) and (c) are not to exceed $5.0 million in aggregate, and (d) unpaid indemnification losses of PMH (defined in the APA as the "Unpaid Losses") of up to $4.5 million, (the "Commitment Amount"). *FF21* GWHN's debt and pension obligations will also be addressed as a result of the transaction. At the time of the Closing and as permitted thereafter, the purchase price (less adjustments) together with GWHN's cash, investments and debt service reserve funds (but excluding charitable funds) will be used to satisfy GWHN's obligations. GWHN's unfunded pension liabilities with respect to its multi-

employer defined benefit health plan are estimated to be at least $27 million and, with respect to its cash balance plan, are approximately $12 million. *FF25*

With the proposed Asset Purchase, the parties expect that PMH will provide sufficient capital to meet deferred, current and future capital needs for the Hospital's physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology. With PMH's access to capital, the post-closing New Hospital will have the financial resources to purchase new technology, upgrade its facilities, attract skilled providers, and upgrade electronic health records, in addition to investing in service line development, physician alignment and recruitment and development of increasing ambulatory access. *FF34* On the Closing Date, the assets of GWHN will be transferred to Prospect Connecticut, Inc. ("New GWHN") or one or more of its affiliates. New GWHN will serve as the health system parent company and sole shareholder of Prospect Waterbury, Inc., which will hold the Hospital's license after Closing (the post-closing hospital will be referred to as "New Hospital"). *FF27*

Following Closing, the New Hospital will be governed by a board of directors controlled by PMH (the "New Hospital Board"). The New Hospital Board will have oversight and ultimate authority over the affairs of the New Hospital and the purchased assets. The New Hospital Board will be composed of executives of PMH and local employed executives of GWHN. *FF38* The New Hospital Board will be advised by a local advisory board, anticipated to be comprised of five current members of the GWHN Board, five physicians, and the CEO of the New Hospital (the "Local Board"). The Local Board will serve as a resource for PMH with respect to development and review of strategic plans, assist with maintenance and implementation of a strategic business plan for the New Hospital, and assist with medical staff credentialing, quality assurance programs and accreditation at the New Hospital. *FF39*

The capital projects in the table below have been identified by GWHN management as priority capital projects to be addressed within the first three years after Closing. *FF32*

CAPITAL PRIORITY PROJECTS IDENTIFIED BY GWHN

Description	Estimated Cost (In Millions)	Estimated Timeframe (In Months)
Facility – Main Campus		
Expansion of ED/Development of urgent care*	$3.75	24-36
Upgrade OB/Women's health	$2.0	6-18
Upgrade outpatient surgery**	$2.0	6-18
Equipment		
Replace interventional radiology equipment	$1.7	12-18
Upgrade surgical/anesthesia equipment	$1.5	12-18
Outpatient Centers (Southbury, Naugatuck and Waterbury)* **	N/A	N/A
Physician Recruitment	N/A	N/A
Information Technology		
Continue IT Plan	N/A	N/A

Implement outpatient/physician practice strategy	N/A	N/A
Patient Safety****	$3.24	12-36
Total Estimated Cost	**$14.2**	

PMH plans to establish a strong physician network by recruiting high quality physicians to GWHN's medical staff. PMH has developed significant experience in other markets regarding methods of attracting more primary care providers and improving access to care. Recently, PMH succeeded in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners participating in PMH's Rhode Island physician network at the end of 2015, only 18 were employed by the CharterCare System when PMH acquired its two hospitals (RWMC and OLFH) in mid-2014. *FF41*

With respect to its quality of health care services, PMH has had to significantly modify its Quality Assurance and Performance Improvement ("QAPI") as a result of recent surveys of two PMH hospitals in California, Los Angeles Community Hospital and Southern California Hospital, resulting in the California Department of Health imposing Immediate Jeopardy citations. *FF55* GWHN representatives learned of the Immediate Jeopardy citations on February 11, 2016. In response, the GWHN Board appointed a task force to review the citations and corrective actions taken and to recommend whether or not to proceed with the transaction. The task force reviewed the deficiencies and corrective action plans, conducted interviews, and made site visits to PMH-owned hospitals in both California and Rhode Island. The task force determined that PMH was committed to quality and proposed that GWHN obtain certain assurances from PMH and move forward with the transaction. *FF56* Accordingly, on April 27, 2016 the parties entered into a Quality Assurance Commitment Letter pursuant to which PMH agreed to maintain certain GWHN quality programs for the first two years after the Closing and to not modify them without approval of the Local Board. The Quality Assurance Commitment Letter also requires that PMH maintain QAPI programs consistent with best practices and those currently implemented in PMH's Rhode Island facilities while also acknowledging that the Local Board shall oversee quality programs at the New Hospital. *FF57*

PMH aligns its hospitals and physicians under a model called Coordinated Regional Care ("CRC"). CRC provides for clinical integration of hospitals, physicians and community providers with health plans and other payers through value driven and risk-based reimbursement systems. PMH believes that the CRC model improves quality, efficiency and financial performance while providing its patients with quality, affordable healthcare. *FF15* The goal of the CRC model is to reduce the overall cost of health care by increasing preventive care and reducing readmissions, inpatient utilization and emergency room visits. PMH will achieve these goals by developing a healthcare delivery network encompassing the entire continuum of patient care, including inpatient services, home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health related services. *FF43* PMH has demonstrated the efficacy of the CRC model in Southern California, Texas and Rhode Island. In these regions, PMH has improved clinical outcomes, increased quality scores, increased patient satisfaction, reduced readmission rates, reduced average lengths of stay, and reduced medical-cost ratios. For example, from 2012 to 2014 in California and Texas, where

PMH participates in HMO contracts for seniors, PMH reduced hospital bed days per thousand patients from 1,260 to 720. Additionally, length of hospital stay for this population has been reduced from 5.1 to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. The CRC model has also enabled PMH to attract more primary care providers and has improved access to care. *FF44*

In addition to addressing any quality issues, PMH has also agreed to adhere to GWHN's charity care policies for at least the first five years after Closing. For the first five years, PMH has also agreed to participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, provide public health programs of educational benefit to the community, and to generally promote public health, wellness, and welfare to the community by operating the New Hospital with quality standards consistent with other hospitals owned by PMH. *FF45* PMH will continue to provide financial support for community benefit and community building activities in the Waterbury area to the same degree as GWHN did in FY 2014. The spending by PMH for community building activities post-closing is projected to increase 1% each year through FY 2019, and the spending for both community benefit and community building activities post-closing assumes no change in the Medicaid population served or the complement of community benefit programs offered by the New Hospital. *FF46*

In 2013, the Hospital conducted a Community Health Needs Assessment ("CHNA"), which identified current and future health care needs of the community. The priority areas identified for the greater Waterbury community were access to care, mental health/substance abuse, overweight/obesity, and smoking/tobacco use. An implementation plan was developed to respond to the identified health needs, which PMH has agreed to support. Additionally, the Hospital has traditionally taken a lead role in developing the CHNA, and PMH has agreed to maintain GWHN's current level of involvement in developing and implementing the CHNA for five years from the Closing. *FF49* PMH has also stated that the New Hospital will be in compliance with the following general community benefit standards for at least the first three years after the Closing: (a) the New Hospital will have an open medical staff and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors and (b) the New Hospital will operate a 24/7 emergency department and provide emergency services to patients regardless of their ability to pay. *FF50* PMH and GWHN representatives have already met with leadership for Connecticut's Medicaid Program at the Department of Social Services ("DSS") and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. PMH is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state. In addition, PMH will actively work with other providers in the community such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the Service Area, including Medicaid recipients. *FF51*

Financial benefits associated with this proposal include: operational efficiencies and economies of scale, the New Hospital's participation in PMH's purchasing power, supply chain benefits, employee benefits savings and streamlined revenue collection. PMH also makes available to its

hospitals subject matter consultants who are employed by PMH, saving its hospitals the cost of hiring consultants in those areas. *FF53*

In its audited financial statements for FY 2015, PMH reported total revenues of over $1.3 billion from its operations on a consolidated basis. As of fiscal year end 2015, PMH reported free cash flow of over $112 million and close to $75 million in cash from operations. The company also received credit upgrades by both Moody's and S&P in 2015, with Moody's rating PMH's bonds as B1 and S&P rating PMH's bonds as B. These ratings still stand as of May 3, 2016. *FF19*

Based upon the aforementioned discussion of the evidence provided by the Applicants in this matter, the Applicants have satisfactorily demonstrated that PMH has made a commitment to provide health care to the uninsured and the underinsured; safeguard procedures are in place to avoid a conflict of interest in patient referral; and certificate of need authorization is justified in accordance with the principles and guidelines set forth in Connecticut General Statutes § 19a-639; those being, access to healthcare services, quality of the healthcare services, public need for the proposed project, and the financial feasibility of the proposed project.

Order

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request for the sale of the assets of GWHN and its controlled affiliates to PMH or one or more affiliates of PMH is hereby **Approved** under Conn. Gen. Stat. §§ 19a-486 and 19a-639 subject to the enumerated conditions (the "Conditions") set forth below.

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns, regardless of whether New GWHN remains the parent company and sole shareholder of the New Hospital. OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, including, but not limited to, Conn. Gen. Stat. § 19a-486g and the right to impose and collect a civil penalty under Conn. Gen. Stat. § 19a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. Within twenty (20) days following the Closing of the Asset Purchase authorized by this Order, Applicants shall submit a schedule to OHCA setting forth Waterbury Hospital's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the Decision Date and publish this same information on the website of the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(8) & (11); FF 18, 30*

2. Within twenty (20) days following the Closing of the Asset Purchase authorized by this Order, Applicants shall identify and provide the Certificate of Incorporation for the PMH affiliated entity that shall directly own, operate and hold the hospital license of the New Hospital post-closing. This entity shall be duly organized and validly existing under the laws of Connecticut and New GWHN shall be its parent company and sole shareholder as proposed in the CON application. OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(8) & (11); FF 27*

3. Applicants shall notify OHCA in writing of the Closing of the Asset Purchase authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:

    a. the APA, including any and all schedules and exhibits; and

    b. Bylaws or similar governance documents for New GWHN, as well as for the New Hospital.

The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If the Applicants redact materials in accordance with the previous sentence, the Applicants shall provide a list to OHCA which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a) & 19a-613(b); FF 20, 21, 38, 39*

4. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement GWHN's 2016 CHNA and for conducting the New Hospital's next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following:

   (i) the data that will be collected and analyzed to systematically assess health status indicators of the Service Area;
   (ii) the identity of key community stakeholders and health organizations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation;
   (iii) the qualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined;
   (iv) the frequency with which the Study will be repeated;
   (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the community; and
   (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospital.

   OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3) & (7); FF 49*

5. Within three (3) years following the Closing, PMH shall participate with New GWHN and the New Hospital, and the key community stakeholders and health organizations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/hct2020/hct2020_state_hlth_impv_032514.pdf), as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on New Hospital's website. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement GWHN's current CHNA for the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 49*

6. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospital for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 30, 34, 43, 46*

7. Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website of the New Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 30*

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of enhancing the understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and using evidence-based interventions.

8. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New Hospital and its affiliates from the Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project;

    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and

    c. The dates and amounts of withdrawals from the New Hospital's operating account and/or any other sources of funding used to fulfill the Capital Commitment.

    The reports shall be signed by the New GWHN's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 29, 31-34*

9. For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for New GWHN and the New Hospital, respectively:

    a. The cost saving totals achieved in the following Operating Expense Categories for New GWHN and New Hospital: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

        1. the major cost savings achieved for each expense category for the semi-annual period; and

        2. the effect of these cost savings on the clinical quality of care.

    b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New GWHN and New Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 29, 31-34*

10. For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New GWHN and New Hospital, respectively. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report:

Financial Measurement/Indicators

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

3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 18, 36*

11. PMH shall ensure that the New Hospital maintains and adheres to GWHN's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as GWHN's current policies consistent with state and federal law. These policies shall be posted on the website of the New Hospital and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45, 46*

12. For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of the New Hospital within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of the New Hospital simultaneously with its submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45, 46*

13. PMH shall maintain community benefit programs and community building activities for the New Hospital for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as GWHN's current programs, and PMH shall apply a 1% increase per year for the next three (3) years toward community building activities in terms of dollars spent.

In determining the New Hospital's participation and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the Closing for three years and shall be posted on New Hospital's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 46*

14. The New Hospital agrees to comply with the following general community benefit standards for at least the first three years following the Closing: (a) the New Hospital shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospital shall have an open medical staff and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors; (c) the New Hospital shall participate in the Medicare and Medicaid programs; and (d) the New Hospital shall operate a 24/7 emergency department and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45, 50*

15. The New Hospital shall work toward making culturally and linguistically appropriate services available and integrated throughout its hospital operations. Specifically, the New Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the New Hospital shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the New Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the Closing for three years and shall be posted on the New Hospital's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 45-50*

16. Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who has experience in hospital administration and regulation, including maintaining quality control in an HRO. The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to the New Hospital and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486d(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 18, 34, 45-50, 57*

17. The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of the New Hospital on no less than a semi-annual basis to assess PMH's modified QAPI program and compliance with the Quality Assurance Commitment Letter. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486d(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 18, 34, 45-50, 57*

18. If at any time within three (3) years following the Closing Date, the New Hospital's Local Board agrees with PMH to change any of GWHN's Post Closing Quality Practices described in the Quality Assurance Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and FLIS in writing within thirty (30) days of any such change going into effect. If the Independent Monitor disagrees with the change, OHCA may require that a request for modification be submitted and approved as required by C.G.S. §4-181a to make the change. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 57*

19. For three (3) years following the Closing Date, PMH shall hold a meeting of the New Hospital Board and the Local Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospital's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 38, 39*

20. For three (3) years following the Closing Date, PMH shall allow for one (1) community representative to serve as a voting member of the Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representative shall be selected in consultation with the Mayor of Waterbury in order to ensure the appointment of an unbiased person who will fairly represent the interests of the community served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 38, 39*

21. PMH, New GWHN and the New Hospital shall abide by all requirements of licensure that may be imposed by FLIS in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 54, 57*

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

July 15, 2016
Date

Janet M. Brancifort
Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, July 19, 2016 3:29 PM
To: Kathleen Gedney
Cc: Michele Volpe; Jennifer O'Donnell; Hansted, Kevin; Martone, Kim; Riggott, Kaila; Greer, Leslie
Subject: RE: Docket No. 15-32016-486 and 15-32017-486 - Confirmation of approval of Supplemental Imaging Applications

Good Afternoon,

I double checked with OHCA's legal advisor and we can confirm that the two decisions rendered under Docket Numbers: 15-32016-486 and 15-32017-486, include all the assets requested in the two applications, including the MRI, CT and PET/CT scanners requested to be acquired by PMH in the supplemental applications filed in the two dockets. I will place a copy of this email in the original files for the two dockets for future reference. If you have any additional questions, please do not hesitate to contact us.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Friday, July 15, 2016 3:29 PM
To: Lazarus, Steven
Cc: Michele Volpe; Jennifer O'Donnell
Subject: Docket No. 15-32016-486 and 15-32017-486 - Confirmation of approval of Supplemental Imaging Applications

Hi Steven:

Thank you for speaking with me yesterday about the supplemental advanced imaging applications included in both the Eastern Connecticut Health Network, Inc. ("ECHN") and Greater Waterbury Health Network, Inc. ("GWHN") Conversion Applications.

In our call yesterday, you stated that it was OHCA's position that the three supplemental applications filed with the ECHN Conversion Application re Docket No. 15-32016-486 ((1) Acquisition of Manchester Memorial Hospital's MRI, PET/CT and CT scanners as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.; (2) Acquisition of Rockville General Hospital's MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.; and (3) Acquisition of Rockville General Hospital's off-site MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.) are approved as part of the Final Decision re Docket No. 15-32016-486. In lieu of any formal correspondence from OHCA regarding the approval of these supplemental applications, would you kindly confirm by responding to this email that the above statement is accurate?

Additionally, please confirm that the GWHN Final Decision Docket No. 15-32017-486 issued today similarly approves the supplemental application (Acquisition of Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.) filed with Conversion Application Docket No. 15-32017-486?

Thank you very much,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, August 18, 2016 10:54 AM
To: Greer, Leslie
Subject: FW: OAG Docket No. 15-486-02 / OHCA Docket No. 15-32017-486 - Closing Date
Attachments: GWHN Notice of Closing Date.pdf

Please add the following correspondence to the original file.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Thursday, August 18, 2016 10:53 AM
To: Hansted, Kevin; Hawes, Gary W.; Martone, Kim; Lazarus, Steven
Cc: Zinn-Rowthorn, Perry A.; Salton, Henry A.; 'AZucker@carmodylaw.com'; 'dstromstad@wtbyhosp.org'; Jonathan Spees; Michele Volpe; Jennifer O'Donnell
Subject: OAG Docket No. 15-486-02 / OHCA Docket No. 15-32017-486 - Closing Date

Please see attached regarding the closing date in the above captioned matter.

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
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BERSHTEIN, VOLPE & McKEON, P.C.
ATTORNEYS AT LAW
105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
TELEPHONE: (203) 777-5800
FACSIMILE: (203) 777-5806

Michele M. Volpe
203-777-6995

August 17, 2016

VIA EMAIL AND US MAIL (kevin.hansted@ct.gov; gary.hawes@ct.gov; Kimberly.martone@ct.gov; steven.lazarus@ct.gov)

Attorney General George Jepsen
Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Closing Date for Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31217-486 and Attorney General Docket No. 15-486-02

Dear Mr. Jepsen and Ms. Brancifort:

On behalf of Prospect Medical Holdings, Inc. in connection with the above referenced matters, this letter shall serve as written notice to your respective offices regarding the closing date of the transaction. The closing has been scheduled for **October 1, 2016** subject to satisfaction of all required closing conditions. With respect to Condition 2 of the Attorney General Final Decision, this letter shall serve as the requested written notice of the closing date. Should this date change, we will notify your respective offices of such new closing date.

If you have any questions or require anything further, please contact me at 203-777-6995. Thank you for your assistance in this matter.

Very truly yours,

Michele M. Volpe,
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Henry Salton, Assistant Attorney General, Office of the Attorney General
Gary Hawes, Associate Attorney General, Office of the Attorney General
Ann Zucker, Carmody Torrance Sandak & Hennessey, LLP
Darlene Stromstad, Greater Waterbury Health Network, Inc.
Jonathan Spees, Prospect Medical Holdings, Inc.

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, September 13, 2016 8:05 AM
To: Greer, Leslie
Subject: FW: PMH/GWHN re CA DPH Survey Letter-OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02
Attachments: PMH GWHN re CA DPH Survery Letter.pdf; CSMS Survey Letter.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, September 12, 2016 4:24 PM
To: Martone, Kim; Lazarus, Steven; Hansted, Kevin; McLellan, Rose; Cass, Barbara; Zinn-Rowthorn, Perry A.; Salton, Henry A.; Hawes, Gary W.; Shapiro, Daniel R.; Ann H. Zucker; Stromstad, Darlene
Cc: Michele Volpe; Jonathan Spees; 'Von.crockett@prospectmedical.com'
Subject: PMH/GWHN re CA DPH Survey Letter-OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02

All: Attached please find correspondence in connection with the above captioned matter. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
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Michele M. Volpe
203-777-6995

September 12, 2016

VIA EMAIL AND US MAIL

Attorney General George Jepsen
Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Prospect Medical Holdings Inc./Greater Waterbury Health Network, Inc. re California Department of Public Health Survey Letter re Southern California Hospital – OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02

Dear Mr. Jepsen and Ms. Brancifort:

For your records and as a follow up to Prospect Medical Holdings proposed acquisition of Greater Waterbury Health System entities, attached please find a letter from the California Department of Public Health dated September 8, 2016 clearing Southern California Hospital, a Prospect Medical Holdings entity, from the CSMS licensure termination track.

If you have any questions or require anything further, please contact me at 203-777-6995. Thank you for your assistance in this matter.

Very truly yours,

Michele M. Volpe,
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Rose McLellan, License and Application Supervisor, Facility Licensing & Investigations Section
Barbara S. Cass, R.N., Section Chief, Facility Licensing and Investigations Section
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Henry Salton, Assistant Attorney General, Office of the Attorney General
Gary Hawes, Assistant Attorney General, Office of the Attorney General
Daniel Shapiro, Assistant Attorney General, Office of the Attorney General
Ann Zucker, Carmody Torrance Sandak & Hennessey, LLP
Darlene Stromstad, Greater Waterbury Health Network, Inc.
Jonathan Spees, Prospect Medical Holdings, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

CENTERS FOR MEDICARE & MEDICAID SERVICES

Refer to: WDSC- mc

09/08/2016

Administrator
Southern California Hospital at Hollywood
6245 De Longpre Ave
Hollywood, CA 90028

CMS Certification Number (CCN): 050135

Dear Administrator:

The California Department of Public Health (CDPH) has determined that Southern California Hospital at Hollywood now meets the Medicare Conditions of Participation for a provider of hospital services and therefore, this office will not proceed with a termination action. The authority for this decision is found at 42 C.F.R. § 498.20 - 498.25.

The 07/28/2016 revisit survey conducted by the CDPH determined that the hospital demonstrated compliance with Medicare Conditions of Participation (CoP) and provides the basis for the determination of CMS.

Therefore, effective the date of this letter, we are removing your facility from the CDPH survey jurisdiction and restoring your facility's deemed status, based on your continued accreditation by the DNV GL–Healthcare (DNV GL). While the survey found compliance with the CoP there are standard level deficiencies cited. The enclosed Statement of Deficiencies (CMS-2567) documents the findings of the 07/28/2016 survey.

Since your hospital has been determined to be in compliance with the CoP you do not have to submit a plan of correction for any of the Medicare survey deficiencies. However, under Federal disclosure rules a copy of the findings of this Medicare survey must be publicly disclosed within 90 days of the completion. You may therefore wish to submit for public disclosure, your comments on the survey findings, and any plans you may have for correcting the cited deficiencies.

Should you choose to submit a plan for correction, the evidence of correction is to be entered on the right side of Form CMS-2567 for both documents, opposite the deficiency, and must be signed and dated by the administrator or other authorized official. Please submit your evidence of correction to the CDPH, Los Angeles District office by close of business, within ten (10) days of receipt of this letter.

The evidence of correction of each item must contain the following:

1. How the correction was accomplished, both temporarily and permanently for each individual affected by the deficient practice, including any system changes that must be made.

2. The title or position of the person responsible for correction, i.e., Administrator, Director of Nursing or other responsible supervisory personnel.

3. A description of the monitoring process to prevent recurrences of the deficiency, the frequency of the monitoring and the individual(s) responsible for the monitoring.

4. The date when the immediate correction of the deficiency will be accomplished, normally this will be no more than thirty (30) calendar days from the date of the exit conferences.

We have forwarded a copy of this letter and the findings from this survey to the DNV GL for its review. Copies of this letter are being sent to the CDPH and the State Medicaid agency.

If you have any questions about this matter, please contact Alex Garza at 415-744-2830, or Maureen Calacal of my staff at 415-744-3727.

Sincerely,

Rufus Arther, Manager
Non-Long Term Care Branch
Division of Survey and Certification

Enclosure

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

RECEIVED
SEP 28 2016
Office of
HEALTHCARE ACCESS

September 19, 2016

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

State of Connecticut
Department of Public Health
410 Capitol Avenue
[illegible]
Hartford, CT 06134

Re: Memorandum of Understanding dated January 23, 2006 between Manchester Memorial Hospital ("Assignor"), and State of Connecticut Department of Public Health (as amended from time to time, the "Agreement")

Dear Sir or Madam:

We are pleased to announce that Eastern Connecticut Health Network, Inc. ("ECHN") intends to join Prospect Medical Holdings, Inc. ("PMH"). Assuming the receipt of all required regulatory approvals and satisfaction of other closing conditions, the parties intend to consummate the proposed transaction (the "Transaction") on or about October 1, 2016 (the "Closing Date").

In connection with the Transaction, ECHN will, on behalf of itself and its subsidiaries, including The Manchester Memorial Hospital, The Rockville General Hospital, Incorporated, ECHN Eldercare Services, Inc., Visiting Nurse and Health Services of Connecticut, Inc. and its wholly owned subsidiary A Caring Hand, LLC, Clinically Integrated Network of Eastern Connecticut, LLC, Eastern Connecticut Medical Professionals Foundation, Inc., Connecticut Healthcare Insurance Company, Inc., ECHN Corporate Services, Inc. and its wholly owned subsidiary Medical Practice Partners, LLC, and ECHN Enterprises, Inc. and its wholly owned subsidiary Haynes Street Property Management, LLC (collectively, "Affiliates"), transfer all or substantially all of the assets of ECHN and its Affiliates to one or more affiliates of PMH. The assets to be transferred include all of the rights and obligations of Assignor under the Agreement.

We are sending this letter to notify you of ECHN's plans to assign the Agreement to Prospect Manchester Hospital, Inc., an affiliate of PMH (the "Assignee"). The Assignee will assume all of the rights and obligations of ECHN and/or its Affiliate(s) under the Agreement arising on or after the Closing Date.

ECHN Contract No. 2005-384

Following the Closing Date, all invoices or further correspondence to Assignee regarding the Agreement shall be sent to:

President & CEO
Prospect ECHN, Inc.
71 Haynes Street
Manchester CT 06040

with a copy of any correspondence or legal notice to:

Prospect ECHN, Inc.
c/o Prospect Medical Holdings, Inc.
3415 South Sepulveda Boulevard, 9th Floor
Los Angeles, CA 90034
Attn: General Counsel
Fax: (310) 943-4501
[illegible]@prospectmedical.com

If you have any questions regarding this letter, please contact me at (860) 533-3427.

Sincerely,

Viola Hughes
Paralegal & Contract Administrator
Legal Department
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040
Phone: (860) 533-3427
Fax: (860) 533-3437
Email: vhughes@echn.org

Greer, Leslie

From: Martone, Kim
Sent: Thursday, October 06, 2016 1:18 PM
To: Roberts, Karen; Cotto, Carmen
Cc: Greer, Leslie
Subject: FW: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-32017-486
Attachments: Ltr to JBrancifort re GWHN (fwding Cert of Incorp) 10.6.16.pdf; Prospect Waterbury, Inc.-CT-Cert Copy of Articles of Inc.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Thursday, October 06, 2016 12:42 PM
To: Brancifort, Janet
Cc: Martone, Kim; Lazarus, Steven; Hansted, Kevin; 'ellen.shin@prospectmedical.com'; Jonathan Spees; dstromstad@wtbyhosp.org; Michele Volpe
Subject: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-32017-486

Please see attached letter and Certificate of Incorporation from Michele Volpe. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

This transmittal may be a confidential attorney-client communication or may otherwise be privileged or confidential. If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, dissemination, distribution or copying of this transmittal is strictly prohibited. If you suspect that you have

BERSHTEIN, VOLPE & McKEON, P.C.
ATTORNEYS AT LAW
105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
TELEPHONE: (203) 777-5800
FACSIMILE: (203) 777-5806

Michele M. Volpe
Direct Dial (203) 777-6995

October 6, 2016

VIA EMAIL (janet.brancifort@ct.gov; Kimberly.martone@ct.gov; steven.lazarus@ct.gov; kevin.hansted@ct.gov)

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-32017-486

Dear Ms. Brancifort:

Pursuant to Condition Number Two (2.) in the Final Decision for Docket No. 15-32017-486, enclosed please find the following Certificate of Incorporation for the PMH affiliated entity that will directly own, operate and hold the hospital license of the New Hospital:

1) Prospect Waterbury, Inc.

Very truly yours,

Michele M. Volpe,
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Ellen Shin, Prospect Medical Holdings, Inc.
Jonathan Spees, Prospect Medical Holdings, Inc.
Darlene Stromstad President and Chief Executive Officer, Greater Waterbury Health Network, Inc.

FILING #0005531924 PG 01 OF 04 VOL B-02176
FILED 04/08/2016 04:00 PM PAGE 01184
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

CERTIFICATE OF INCORPORATION
OF
PROSPECT WATERBURY, INC.

(a Connecticut business corporation)

FIRST: The name of the corporation shall be PROSPECT WATERBURY, INC. (the "Corporation").

SECOND: The authorized capital stock of the Corporation shall consist of one thousand (1,000) shares of common stock, at par value $0.01 per share.

THIRD: The common stock shall have the following rights and privileges:

(a) Voting Rights. Each holder of record of common stock shall be entitled to one vote for each share of stock held.

(b) Voting Requirements. Stockholder action on any matter whatsoever shall require the affirmative vote of at least a majority of the shares of the common stock issued and outstanding at the time of such vote, and for those matters for which the vote of a greater proportion of such shares may be specified by law, the affirmative vote of the proportion of such shares so specified shall be required.

(c) Preemptive Rights. No holder of the common stock shall be entitled as of right to purchase or subscribe for any unissued shares of the Corporation whether now or hereafter authorized or whether of a class hereafter created, or to purchase or subscribe for any bonds, certificates of indebtedness, debentures, or other obligations convertible into shares of the Corporation.

(d) Dividends. The holders of the common stock shall be entitled to receive dividends as and when declared by the Board of Directors of the Corporation.

FOURTH: The name and address of the Corporation's registered agent and office in the State of Connecticut is C T Corporation System, One Corporate Center, Hartford, Connecticut, 06103-3220.

FIFTH: The name and complete address of the incorporater is as follows:

NAME	MAILING ADDRESS
Leonard Lipsky, Esq.	Epstein Becker & Green, P.C. 250 Park Ave New York, NY 10177

SIXTH: The management of the business and the conduct of the affairs of the Corporation shall be vested in a board of directors (the "Board of Directors"). The number of directors which shall constitute the whole Board of Directors shall be fixed by, or

Email: None

in the manner provided in, the bylaws of the Corporation. No election of directors needs to be by written ballot.

SEVENTH: The nature of the business or purposes to be conducted and promoted by the Corporation shall be to operate a licensed hospital and to engage in any lawful act or activity for which corporations may be organized under Connecticut law. The foregoing provisions of this SEVENTH Article shall be construed both as purposes and powers and each as an independent purpose and power, and shall not be held to limit or restrict in any manner the purposes and powers of the Corporation; provided that the Corporation shall not conduct any business, promote any purposes, or exercise any power or privilege within or without the State of Connecticut which, under the laws thereof, the Corporation may not lawfully conduct, promote, or exercise.

EIGHTH: The Corporation is to have perpetual existence.

NINTH: The Board of Directors of the Corporation has the power to adopt, amend, or repeal the bylaws of the Corporation.

TENTH: The personal liability of a director of the Corporation for monetary damages for breach of duty as a director shall be limited to an amount that is equal to the compensation received by the director for serving as a director of the Corporation during the year of the violation if such breach did not (A) involve a knowing and culpable violation of law by the director, (B) enable the director or an associate, as defined in Section 33-840 of the Connecticut Business Corporation Act, to receive an improper personal economic gain, (C) show a lack of good faith and a conscious disregard of the duty of the director to the Corporation under circumstances in which the director was aware that this conduct or omission created an unjustifiable risk of injury to the Corporation, (D) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the director's duty to the Corporation, or (E) create liability under Section 33-757 of the Connecticut Business Corporation Act.

ELEVENTH: (a) The Corporation shall indemnify any individual made a party to a proceeding because such individual is or was a director of the Corporation against liability incurred and expenses advanced in connection with the proceeding in all circumstances except those for which the Connecticut Business Corporation Act prohibits the limitation of such individual's liability.

(b) The Corporation shall indemnify any individual made a party to a proceeding because such individual is or was an officer of the Corporation against liability incurred and expenses advanced in connection with the proceeding to the greatest extent allowed under Connecticut General Statues Section 33-776.

IN WITNESS WHEREOF, the undersigned being the incorporator hereinbefore named, for the purpose of forming a corporation pursuant to the Connecticut Business Corporation Act, does make this Certificate, hereby declaring and certifying that this is my act and deed, that the facts herein stated are true and accordingly have hereunto set my hand this 7th day of April, 2016.

Leonard Lipsky, Esq.
Incorporator

FILING #0005531924 PG 04 OF 04 VOL B-02176
FILED 04/08/2016 04:00 PM PAGE 01187
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

C T Corporation System

Business Address:

One Corporate Center,
Hartford, CT 06103-3200

Acceptance of Appointment: C T Corporation System

By: Kathryn A Widdoes

Kathryn A. Widdoes, Assistant Secretary
(Signature of Agent)

STATE OF CONNECTICUT
OFFICE OF THE SECRETARY OF THE STATE } SS. HARTFORD

I hereby certify that this is a true copy of record in this Office.
In Testimony whereof, I have hereunto set my hand and affixed the Seal of said State, at Hartford,
this 11th day of April A.D. 2016

SECRETARY OF THE STATE

Greer, Leslie

From: Garrison De Lee (Legal Department) <Garrison.DeLee@prospectmedical.com>
Sent: Wednesday, October 19, 2016 2:58 PM
To: User, OHCA
Cc: Darlene Stromstad - Waterbury
Subject: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc.--OHCA Docket No. 15-32017-486-CON
Attachments: SPMHLEGAL16101911590.pdf; Outpatient services and inpatient bed allocation.pdf

To whom it may concern:

Pursuant to Condition Number One (1) in the final Decision for Docket NO. 15-32017-486, attached please find a schedule setting forth Waterbury Hospital□s inpatient bed allocation and the location and hours of operation for all outpatient services by department, as of the Decision Date. This information will be published on the website of the Hospital.

Garrison G. DeLee
Assistant General Counsel
Prospect Medical Holdings, Inc.
310-943-4500

NOTICE: This message and any attachment(s) may contain PRIVILEGED and CONFIDENTIAL information that is proprietary to Prospect Medical and is intended only for the use of the specific individual(s) to which it is addressed. It may contain Protected Health Information that is privileged and Confidential Protected Health Information may be used or disclosed in accordance with law and you may be subject to penalties under law for improper use or further disclosure of the Protected Health Information in this email. If you are not an intended recipient of this email, you are hereby notified that any unauthori□ed use, dissemination or copying of this email or the information contained in it or attached to it is strictly prohibited. If you have received this email in error, please delete it and immediately notify the person named above by reply email.

PROSPECT MEDICAL HOLDINGS, INC.

3415Sepulveda Boulevard
9th Floor
Los Angeles, CA 90034
Tel (310) 943-4500
Fax (310) 943-4501

October 19, 2016

VIA EMAIL
Office of Healthcare Access
Connecticut Department of Public Health
410 Capital Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc.— OHCA Docket No. 15-32017-486

To whom it may concern:

Pursuant to Condition Number One (1) in the final Decision for Docket NO. 15-32017-486, attached please find a schedule setting forth Waterbury Hospital's inpatient bed allocation and the location and hours of operation for all outpatient services by department, as of the Decision Date. This information will be published on the website of the Hospital.

If you have any questions, please contact the undersigned.

Sincerely,

Garrison G. DeLee
Assistant General Counsel

cc: Darlene Stromstad

Service	Location	Hours	Number of beds
Alliance Medical group	1625 Straits Turnpike		
Middlebury	Middlebury, CT 06762		
Pediatrics	Suite 302	Mon. - Thur. 9 a.m. to 6:45 p.m.	
		Friday 9 a.m. to 4:45 p.m	
		Sat. and Sun. 9 a.m. to 12 p.m.	
Primary Care	Suite 110	Mon. - Fri. 9 a.m. to 12 p.m.; 1 p.m. to 4:45 p.m.	
Endicronology	Suite 200	Mon. - Fri. 9 a.m. to 12 p.m.; 1 p.m. to 5 p.m.	
Geriatrics	Suite 304A	Mon. - Fri. 9 a.m. to 12 p.m.; 1 p.m. to 4:45 p.m.	
Neurology	Suite 304A	Mon. - Fri. 9 a.m. to 12 p.m.; 1 p.m. to 4:45 p.m.	
Pulmonary	Suite 200	Mon. - Fri. 9 a.m. to 12 p.m.; 1 p.m. to 5 p.m.	
Rheumatology	Suite 301	Mon. - Thur. 9 a.m. to 4:30 p.m.	
		Fr. 9:30 a.m. to 4:30 p.m.	
Sleeep Center	1625 Straits Turnpike, Suite 305	Mon. - Fri. 8 a.m. to 4:30 p.m.	
	Middlebury, CT 06762	7 p.m. to 7 a.m.	6
Surgery	Suite 200	Mon. - Fri. 9 a.m. to 12 p.m.; 1 p.m. to 5 p.m.	
Weight Management	Suite 200	Mon. - Fri. 9 a.m. to 12 p.m.; 1 p.m. to 5 p.m.	
Naugatuck	305 Church St.	Mon. Thur. 8 a.m. to 5 p.m.	
		Tue. Wed. 8:30 a.m. to 7 p.m.	
		Fri. 10 a.m. to 5 p.m.	
Thomaston	130 South Main Street	Mon. - Friday 9 a.m. to 4:30 p.m.	
Waterbury	140 Grandview Ave.	Mon. - Fri. 8:30 a.m. to 5 p.m.	
Chase Outpatient Center	160 Robbins Street	Mon. - Fri. 8:30 a.m. to 5 p.m.	
Watertown	51 Depot Street, Suite 506	Mon., Wed., Thur., Fri. 10 a.m. to 4:30 p.m.	
Woodbury	40 Main Street North	Mon. - Fri. 9 a.m, to 5 p.m.	
Cardiology Associates of	455 Chase Parkway		
Greater Waterbury	Waterbury, CT 06708	8:30 a.m. to 4:30 p.m.	
Cardiac Diagnostic Center	455 Chase Parkway		
	Waterbury, CT 06708	8 a.m. to 5 p.m.	
Chase Outpatient Center	160 Robbins Street	Mon. - Fri. 8:30 a.m. to 5 p.m.	
	Waterbury, CT 06708		
The Harold Leever Regional	1075 Chase Parkway	Mon. - Fri. 7 a.m. to 5 p.m.	
Cancer Center	Waterbury, CT 06708		

VNA Health at Home, Inc.	27 Siemon Company Drive	Mon. - Fri. 8 a.m. to 4 p.m.	
	Watertown, CT 06795		
Valley Imaging Partners	799 New Haven Road (Route 63)		
	Naugatuck, CT 06770	Mon. Tue. Thur. 8 a.m. to 5 p.m.	
		Saturday by appointment only	
Imaging Partners of	134 Grandview Ave. Suite 103	Mon. - Fri. 8 a.m. to 4:30 p.m.	
Waterbury Hospital	Waterbury, CT 06708	Evenings by appointment only	
Greater Waterbury	68 Robbins St.	Mon. - Fri. 6:30 a.m. to 10:30 p.m.	
Imaging Center	Waterbury, CT 06708	Sat. 6:30 a.m. to 8 p.m.	
Physical Rehabilitation			
Access Rehab Centers			
Middlebury	1625 Straits Turnpike	Mon. - Fri. 7:30 a.m. to 7 p.m.	
	Middlebury	Sat. 8 a.m. to 12 p.m.	
Naugatuck	305 Church St. Suite 8	Mon., Wed., Fri. 8 a.m. to 7 p.m.	
	Naugatuck, Ct 06770	Tue., Thur., 8 a.m. to 6:30 p.m.	
Oxford	84 Oxford Road	Mon., Wed., Fri., 8 a.m. to 7 p.m.	
	Oxford, CT 06478	Tue., Thur., 8 a.m. to 3:30 p.m., Sat. 8 a.m. to 12 p.m.	
Southbury	134 Main St.	Mon., Wed., Thur. 8 a.m. to 6 p.m.	
	Bennett Square, # 70-G	Tue. 8 a.m. to 3:30 p.m.; Fri. 8 a.m. to 3 p.m.	
	Southbury, CT 06488		
Thomaston	131 Main St.	Mon., Wed. 8 a.m. to 6 p.m.	
	Thomaston, CT 06787	Tue., Thur., Fri. 8 a.m. to 4:30 p.m.	
Waterbury	22 Tompkins St.	Mon. - Fri. 8 a.m. to 5:30 p.m.	
	Waterbury, CT 06708		
	715 Lakewood Road	Tue., Thur. 8 a.m. to 7 p.m.	
	Waterbury, CT 06704	Mon., Wed., Fri. 8 a.m. to 5 p.m.; Sat. 8 a.m. to 12 p.m.	
	2154 East Main St.	Mon., Wed., 8:30 a.m. to 7 p.m.	
	Waterbury, CT 06705	Tue., Thur., Fri. 8:30 a.m. to 4:30 p.m.; Sat. 8 a.m. to 12 p.m.	
	64 Robbins St.	Mon. - Sun. 8 a.m. to 4:30 p.m.	
	Waterbury, Ct 06708		
Wolcott	650 Wolcott Road	Mon. Tue. Wed. 7:30 a.m. to 7 p.m.	
	Wolcott, CT 06716	Thur. 7:30 a.m. to 4 p.m.; Fri. 7:30 a.m. to 6 p.m.	
Waterbury Hospital			

Blood Drawing Facilities			
Waterbury	64 Robbins Street, Ground Floor	Mon. - Fri. 7 a.m. to 4:30 p.m.	
	Waterbury, CT 06721		
	134 Grandview Ave., Suite 104	Mon. - Fri. 8 a.m. to 12:30 p.m.; 1:30 p.m. to 3:30 p.m.	
	Waterbury, CT 06721		
	160 Robbins Street	Mon. - Thur. 8:30 a.m. to 12:30 p.m.; 1 p.m. to 3:30 p.m.	
	Waterbury, CT 06708	Fri. 8:30 a.m. to 3 p.m.	
Middlebury	1625 Straits Trnpk, Suite 304	Mon. - Fri. 7 a.m. to 4:45 p.m.	
	Middlebury, CT 06762		
Naugatuck	305 Church St., Suite 8	Mon. - Fri. 7 a.m. to 12:30 p.m.; 1 p.m. to 4:30 p.m.	
	Naugatuck, Ct 06770		
Southbury	22 Old Waterbury Road, Suite 201	Mon. - Fri. 7 a.m. to 12:30 p.m.; 1 p.m. to 4 p.m.	
	Southbury, CT 06488		
Thomaston	130 South Main St.	Mon. Tue. Wed. 7 a.m. to 12:30 p.m.; 1 p.m. to 3:45 p.m.	
	Thomaston, CT 06787	Thur. 7 a.m. to 12:30 p.m.; 1 p.m. to 4:15 p.m.	
Watertown	51 Depot Street, Suite 212	Mon. - Fri. 7 a.m. to 12:30 p.m.; 1 p.m. to 4 p.m.	
	Watertown, CT 06795		
Waterbury Hospital			
Nursing Units			
CVU	64 Robbins St.	Open 24 hours a day, 7 days a week	8
MICU	Waterbury, CT 06708		10
SICU			10
FBC			26
TELE			41
P5			34
P6			23 (temporarily closed)
P7			30
P8 Total BH			30
P9			34
Special Care Nursery	64 Robbins St.	Open 24 hours a day, 7 days a week	14
Well Baby	Waterbury, CT 06708		10

EXECUTION VERSION

ASSET PURCHASE AGREEMENT

by and between

GREATER WATERBURY HEALTH NETWORK, INC.

SELLER

and

PROSPECT CT MEDICAL FOUNDATION, INC.
PROSPECT WATERBURY, INC.
PROSPECT WATERBURY HOME HEALTH, INC.

BUYER

Dated as of September 27, 2016

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ASSET PURCHASE AGREEMENT

This **ASSET PURCHASE AGREEMENT** (this "**Agreement**"), dated September 27, 2016, is by and between Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("**Seller**"), on its behalf and on behalf of its Wholly Owned Subsidiaries, on the one hand, and Prospect CT Medical Foundation, Inc., a Connecticut nonstock corporation, Prospect Waterbury, Inc., a Connecticut corporation, and Prospect Waterbury Home Health, Inc., a Connecticut corporation (collectively, the "**Buyer**"), with Prospect Medical Holdings, Inc. ("**PMH**"), a Delaware corporation and the indirect owner of Buyer, joining for the limited purposes described herein, on the other hand.

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of the Seller and its Wholly Owned Subsidiaries, including The Waterbury Hospital (a tax-exempt entity), an acute care teaching hospital having 357 licensed beds (the "**Hospital**"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. ("**GWMRI**"), and Alliance Medical Group, Inc., together with the Hospital's equity interests in Cardiology Associates of Greater Waterbury, LLC ("**CAGW**") (the entities and businesses operated by Seller and its Wholly Owned Subsidiaries, including the Hospital and CAGW, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Access Rehab Centers, LLC, Greater Waterbury Imaging Center Limited Partnership, Imaging Partners, LLC, Heart Center of Greater Waterbury, Inc. ("**Heart Center**"), The Harold Leever Regional Cancer Center, Inc., Waterbury Gastroenterology Co-Management Company, LLC ("**WGCC**"), and Valley Imaging Partners, LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**"); *provided*, that, for the avoidance of doubt, the parties hereby agree and acknowledge that the term "Hospital Businesses" does not include the Joint Ventures or Converted Ventures (as such term is hereinafter defined) or any of their health care facilities, assets or businesses;

WHEREAS, Buyer desires to purchase substantially all of the assets, real, personal and mixed, tangible and intangible, of Seller and the Wholly Owned Subsidiaries, including the Hospital Businesses (including the equity interests in CAGW), the Joint Ventures and Converted Ventures; and

WHEREAS, Seller has concluded that the transactions contemplated by this Agreement are in its best interests and consistent with its charitable mission of the promotion of health care in the communities served by the Hospital Businesses.

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 are forever acknowledged, the parties, intending to be legally bound, agree as follows:

AGREEMENT:

1. DEFINITIONS AND REFERENCES

1.01. Definitions. For purposes of this Agreement, the following definitions apply:

(1) **20-Day Period** is defined in Section 2.05(f);

(2) **Accessibility Laws** is defined in Section 3.11(b)(iv);

(3) **Accountants' Determination** is defined in Section 2.05(f);

(4) **Accounts Receivable** means all accounts, notes, interest, and other receivables of the Hospital Businesses, including, without limitation, those certain accounts, notes, or other receivables listed on Schedule 1.01(4), and all claims, rights, interests, and proceeds related thereto, including all accounts and other receivables, disproportionate share payments, and all rights to receive funds relating to upper payment limits, arising from the rendering of services to inpatients and outpatients at the Hospital Businesses, billed and unbilled, recorded and unrecorded, accrued and unaccrued, for services provided by Seller or the Wholly Owned Subsidiary, as applicable, while owner of the Assets, whether payable by private pay patients, private insurance, third party payors, Government Payment Programs, or by any other source, and accounts that have been written off, but excluding all Cost Report settlement amounts;

(5) **Accumulated Benefit Obligation** means the accumulated benefit obligation of Seller's or its Wholly Owned Subsidiary's, as applicable, defined benefit pension plan, the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan, determined for purposes of Seller's audited financial statements as of September 30, 2015 using GAAP (i) reflecting the assumptions used for purposes of Note 9 of such financial statements (as updated for the RP-2014 mortality tables prepared by the Society of Actuaries) and (ii) assuming continuation of the Seller's or its Wholly Owned Subsidiary's, as applicable, post-retiree health benefit plan and no change in its provisions after September 30, 2015 (other than the freeze of such plan to new participation);

(6) **AEA** is defined in Section 3.12;

(7) **Affiliate** means as to the Person in question, any Person that directly or indirectly controls, is controlled by, or is under common control with the Person 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 a Person, whether through ownership of voting securities, by contract, or otherwise;

(8) **Agreement** is defined in the preamble;

(9) **Arbitrating Accountants** is defined in Section 2.05(f);

(10) **Asbestos Abatement Liability** means the amount reflected in Seller's audited financial statements;

(11) **Asset Sale** is defined in Section 5.03(c);

(12) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets owned by a Wholly Owned Subsidiary of Seller and the JV Interests, but (ii) excluding the Excluded Assets;

(13) **Assignment and Assumption Agreement** is defined in Section 9.02(c);

(14) **Assumed Contracts** is defined in Section 2.01(f);

(15) **Assumed Liabilities** is defined in Section 2.03;

(16) **Attorney General** means the Office of the Attorney General of the State of Connecticut;

(17) **Audited Financial Statements** means the audited consolidated balance sheets of Seller and its Wholly Owned Subsidiaries for the three most recently ended fiscal years, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and the report thereon of Marcum, LLP, independent certified public accountants;

(18) **Balance Sheet Date** is defined in Section 3.06(a);

(19) **Bill of Sale** is defined in Section 9.01(b);

(20) **Bond/Escrow** is defined in Section 5.03(f);

(21) **Buyer** is defined in the preamble;

(22) **Buyer Deductible** is defined in Section 10.04;

(23) **Buyer's Indemnified Persons** means Buyer and its respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(24) **Capital Amount** means Fifty-Five Million Dollars ($55,000,000) less (w) the amount of Capital Lease Obligations assumed by Buyer at Closing in excess of Three Million Dollars ($3,000,000), *provided, however*, that such reduction shall not exceed Three Million Five Hundred Thousand Dollars ($3,500,000), less (x) the Negative Amount, less (y) the Purchase Price Adjustment Shortfall, and less (z) the Unpaid Losses; *provided*, *however*, that in no event shall the Capital Amount be reduced in accordance with (1) clauses (x) and (y) by an amount that in the aggregate is greater than Five Million Dollars ($5,000,000), or (2) clause (z) by an amount greater than Four Million Five Hundred Thousand Dollars ($4,500,000);

(25) **Capital Lease Obligations** is defined in Section 2.03(d);

(26) **CAGW** is defined in the recitals;

(27) **Cash Balance Plan** is defined in Section 8.10;

(28) **CERCLA** is defined in Section 3.12;

(29) **CHA Claims** is defined in Section 2.01(y);

(30) **Claim Notice** means written notification of a Third Party Claim by an Indemnitee to an Indemnifying Party under Article 10, including a Third Party Claim set forth in a "Revenue Agent's Report," "Statutory Notice of Deficiency," "Notice of Proposed Assessment," or any other official written notice from a Taxing authority that Taxes are due or that a Tax audit will be conducted;

(31) **Closing** is defined in Section 9.01(a);

(32) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Wholly Owned Subsidiaries as of the close of business on the Closing Date, which, for the avoidance of doubt, shall include Unfunded Pension Liabilities as a line item thereon, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

(33) **Closing Date** means the date upon which the Closing occurs;

(34) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing;

(35) **CMS** means The Centers for Medicare and Medicaid Services;

(36) **COBRA** means the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;

(37) **Code** means the Internal Revenue Code of 1986, as amended;

(38) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which Seller or any Wholly Owned Subsidiary of Seller is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retirement, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(39) **Converted Venture** is defined in Section 5.19;

(40) **Cost Reports** is defined in Section 6.06;

(41) **CTDEEP** is defined in Section 5.06;

(42) **DOL** means the United States Department of Labor;

(43) **DSH** means a Disproportionate Share Hospital that serves a significantly disproportionate number of low-income patients and receives payments from CMS to cover the costs of providing care to uninsured patients;

(44) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with GAAP consistently applied;

(45) **ECAF** is defined in Section 5.06;

(46) **EFT Account** is defined in Section 2.01(o);

(47) **Employee Benefit Plan** is defined in Section 3.21;

(48) **Employee Lists** is defined in Section 5.03(b);

(49) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, easements, restrictions, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(50) **Environmental Laws** is defined in Section 3.12;

(51) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended;

(52) **ERISA Affiliate** is defined in Section 3.21;

(53) **Essential Service** is defined in Exhibit C;

(54) **Establishment Real Properties** is defined in Section 5.06;

(55) **Estimated Remediation Costs** is defined in Section 5.06;

(56) **Excluded Assets** is defined in Section 2.02;

(57) **Excluded Contracts** is defined in Section 2.02(q);

(58) **Excluded Liabilities** is defined in Section 2.04;

(59) **Final Closing Statement** is defined in Section 2.05(e);

(60) **Final Determination Date** means the earliest to occur of (i) the twenty-first (21st) business day following the receipt by Seller of the Final Closing Statement and Closing Balance Sheets if Seller shall have failed to deliver the Objection Notice to Buyer within the 20-Day Period, (ii) the date on which Seller gives Buyer written notice to the effect that Seller has no objection to Buyer's determination of the amount of the actual Net Working Capital and actual Unfunded Pension Liabilities, (iii) the date on which Buyer and Seller execute and deliver a Settlement Agreement, (iv) the date as of which Buyer and Seller shall have received the Accountants' Determination, and (v) Buyer's failure to deliver the information set forth in Section 2.05(e) within the ninety (90) day period described therein.

(61) **Financial Statements** is defined in Section 3.06;

(62) **FTC** means the United States Federal Trade Commission;

(63) **GAAP** means United States generally accepted accounting principles;

(64) **Government Payment Programs** means federal and state Medicare, Medicaid, CHAMPUS and TRICARE programs, the Connecticut HUSKY Health program, and similar or successor programs with or for the benefit of Governmental Authorities;

(65) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(66) **GWMRI** is defined in the recitals;

(67) **Hazardous Substances** means and includes polychlorinated biphenyls, urea formaldehyde, asbestos, low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, and any substances, materials, constituents, chemicals, pollutants, contaminants, wastes (including medical waste), toxic substances, petroleum and petroleum products, or other elements or products that are included under or regulated by any Environmental Law, including, without limitation, CERCLA, RCRA and AEA;

(68) **Heart Center** is defined in the recitals;

(69) **Hill-Burton Act** means the federal Public Health Service Act, 42 U.S.C. §291, *et seq.*, as amended;

(70) **HIPAA** means the federal Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, as amended;

(71) **Hospital** is defined in the recitals;

(72) **Hospital Businesses** is defined in the recitals;

(73) **HSR Act** means the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(74) **Immaterial Contract** means any Contract to which Seller or any of its Wholly Owned Subsidiaries is a party that requires either the payment by Seller or its Wholly Owned Subsidiaries of $25,000 or less or the provision of goods or the performance of services by Seller or any of its Wholly Owned Subsidiaries having a value of $25,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller or the respective Wholly Owned Subsidiary was to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Section 3.17;

(75) **Indemnifying Party** means any Person obligated to indemnify another Person under Article 10;

(76) **Indemnitee** means any Person entitled to indemnification under Article 10;

(77) **Indemnity Notice** means written notification of a claim for indemnity under Article 10, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to Section 10.05(b);

(78) **Information Systems** means the software (including object and source codes as applicable), hardware, application programs and similar systems owned, licensed or leased by Seller or its Wholly Owned Subsidiary and used in the ownership or operation of any of the Hospital Businesses, whether or not on a system-wide basis;

(79) **Intellectual Properties** means (i) all inventions (whether or not patentable or reduced to practice), all improvements thereto, and all patents, patent applications, and patent disclosures, together with all reissuances, continuations, continuations-in-part, revisions, extensions, and reexaminations thereof, (ii) all trademarks, service marks, trade dress, logos, trade names, corporate names, domain names, and all websites (together with the content therein), including all goodwill associated therewith, and all applications, registrations, and renewals in connection therewith, (iii) all copyrightable works, all copyrights, and all applications, registrations, and renewals in connection therewith, and (iv) all trade secrets and confidential business information (including ideas, research and development, know-how, formulas, compositions, manufacturing and production processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals) that are owned, licensed or leased by Seller or its Wholly Owned Subsidiaries and used in the ownership or operation of the Hospital Businesses, together

with all rights to sue or make any claims for any past, present, or future infringement, misappropriation or unauthorized use of any of the foregoing rights, and the right to all income, royalties, damages and other payments that are now or may hereafter become due or payable with respect to any of the foregoing rights, including damages for past, present or future infringement, misappropriation or unauthorized use thereof;

(80) **Interim Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Wholly Owned Subsidiaries as of the most recent month end available before the Closing;

(81) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments in any other Person, or membership in a not-for-profit business organization, and proceeds from the sale thereof;

(82) **IRS** means the United States Internal Revenue Service;

(83) **Joint Commission** is defined in Section 3.16;

(84) **Joint Ventures** is defined in the recitals;

(85) **JV Interests** is defined in Section 2.01(q);

(86) **Justice Department** means the United States Department of Justice;

(87) **Leased Personal Property** is defined in Section 2.01(c)(ii);

(88) **Leased Real Property** means the real property, together with all buildings, improvements and fixtures thereon, that is leased by Seller or any Wholly Owned Subsidiaries of Seller;

(89) **Legal Requirements** means, with respect to any Person, all federal, state and local statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, policies, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(90) **Loan Agreement** is defined in Section 5.15;

(91) **Local Board** is defined in Section 6.12;

(92) **Losses** means any and all damages, costs, losses (including any diminution in value), liabilities, expenses or obligations (including Taxes, interest, penalties, court costs, costs of preparation and investigation, and attorneys', accountants' and other professional advisors' fees and expenses);

(93) **Material Adverse Effect** means any event, change, or occurrence that, individually or together with any other event, change, or occurrence, would reasonably be

expected to have a material adverse effect on the Assets (whether or not covered by insurance) or on the business, operations, results of operations, prospects, or condition (financial or otherwise) of the Hospital Businesses; *provided*, *however*, that the definition of "Material Adverse Effect" shall be used solely for interpreting Section 8.04 and not for interpreting the phrase "material adverse effect" or "material adverse change" as such phrases may be used in any other context elsewhere in this Agreement; and further provided, that the following will be presumed ***not to constitute a Material Adverse Effect***: (a) general economic or industry conditions generally applicable to hospitals or healthcare facilities within the United States of the State of Connecticut so long as such conditions do not disproportionately affect Seller and the Hospital Businesses; (b) changes or proposed changes to any state or federal law, reimbursement rates or policies of Governmental Authorities that are generally applicable to hospitals or to health care facilities within the United States so long as such changes do not disproportionately affect Seller and the Hospital Businesses; (c) requirements, reimbursement rates, policies, or procedures of third party payors or accreditation commissions or organization that are generally applicable to hospitals or health care facilities within the United States; (d) changes in GAAP; (e) actions specifically required of the parties pursuant to this Agreement; and (f) the "Trailing EBITDA" shall be not less than 80% of the normalized Trailing EBITDA of the same period for the prior year; *provided*, *however*, that if the "Trailing EBITDA" is less than 80% of the normalized Trailing EBITDA of the same period for the prior year, then such occurrence shall constitute a Material Adverse Effect;

(94) **Material Tangible Assets** means any equipment or other material items of tangible property and assets with an original cost in excess of $250,000;

(95) **MMA** is defined in Section 2.01(w);

(96) **Multiemployer Plan** is defined in Section 3.21;

(97) **Negative Amount** is defined in Section 2.05(d);

(98) **Net Hospital Value** is defined in Section 6.08;

(99) **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Seller and its Wholly Owned Subsidiaries acquired by Buyer, including inventory and supplies, drugs, food, Accounts Receivable, other receivables, advance payments, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time), and Net Working Capital shall be calculated in accordance with the methodology set forth on Annex A attached hereto;

(100) **Non-Profit JVs** means Heart Center of Greater Waterbury, Inc. and The Harold Leever Regional Cancer Center, Inc.;

(101) **Notice Period** is defined in Section 10.05(a)(i);

(102) **Objection Notice** is defined in Section 2.05(f);

(103) **Owned Real Property** means real property that is owned (legally or beneficially) by Seller or any Wholly Owned Subsidiary, together with all buildings, improvements and fixtures thereon owned by Seller or any Wholly Owned Subsidiary of Seller, all construction in progress, and all appurtenances, rights, privileges and easements thereto;

(104) **PBGC** means the Pension Benefit Guaranty Corporation;

(105) **Permit** means each license, provider number, permit, right, franchise, concession, certificate, authorization, consent, waiver, certificate of waiver, certificate of need, certificate of exemption, accreditation and registration, or other approval of a Governmental Authority owned or held by Seller or its Wholly Owned Subsidiaries relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(106) **Permitted Encumbrances** means those Encumbrances described on Schedule 3.11(a) as being Permitted Encumbrances;

(107) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(108) **Physician Recruitment Expenditures** means the costs related to the development and implementation of physician engagement strategies, including the costs related to sourcing and screening candidates, entering into and executing the terms of an agreement(s) to relocate a physician, including costs incurred in acquiring such physicians practice or assets, and any other similar expenditures relating to physician recruitment;

(109) **PMH** is defined in the preamble;

(110) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(111) **Purchase Price** is defined in Section 2.05;

(112) **Purchase Price Adjustment** is defined in Section 2.05(g);

(113) **Purchase Price Adjustment Shortfall** is defined in Section 2.05(h);

(114) **RCRA** is defined in Section 3.12;

(115) **Real Property** means the Owned Real Property and the Leased Real Property;

(116) **Restricted Area** is defined in Section 6.03;

(117) **Revenue Procedure** is defined in Section 5.03(b);

(118) **Schedules** means the schedules referred to in this Agreement and attached hereto at the time that this Agreement is executed by each original party hereto;

(119) **Second 20-Day Period** is defined in Section 2.05(f);

(120) **Seller** is defined in the preamble;

(121) **Seller Deductible** is defined in Section 10.02;

(122) **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Affiliates, and, for all of them, their respective members, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(123) **Seller's Withdrawal Liability** is defined in Section 5.03(k);

(124) **Settlement Agreement** is defined in Section 2.05(f);

(125) **State Health Agency** is defined in Section 3.15;

(126) **Surveys** is defined in Section 5.18;

(127) **Target Net Working Capital** means $6,800,000;

(128) **Tax** means any federal, state, local, or foreign income, unrelated business income, gross income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under Section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, employment, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, property, production, ad valorem, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, custom, duty, impost, levy or fee of any kind whatsoever, or other like assessment or charge, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(129) **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code Section 501(c)(3) organization, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(130) **Termination Fee** is defined in Section 9.04(d);

(131) **Third Party Claim** is defined in Section 10.05(a)(i);

(132) **Title Commitment** is defined in Section 5.17;

(133) **Title Company** is defined in Section 5.17;

(134) **Title Policy** is defined in Section 5.17;

(135) **Trailing EBITDA** means the normalized EBITDA of the Seller and its Wholly Owned Subsidiaries on a consolidated basis for the trailing 12-month period through the date of the most recent unaudited statements of income and cash flows of the Seller and its Wholly Owned Subsidiaries provided to Buyer pursuant to Section 5.04(b);

(136) **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*, as amended;

(137) **Transfer Act Activities** is defined in Section 5.06;

(138) **Transitional Services Agreement** means the agreement between Buyer and Seller whereby Buyer or its Affiliate will lease to Seller, at cost, employees of Seller or its Wholly Owned Subsidiaries of the Hospital Businesses who are hired by Buyer as of the Closing Date, for the orderly wind down of the benefits and administration of Seller's other post-Closing obligations (*e.g.*, finalizing Cost Reports), in substantially the form of Exhibit A attached hereto;

(139) **Unaudited Financial Statements** means the unaudited consolidated balance sheets of Seller and its Wholly Owned Subsidiaries as of June 30, 2016, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the 9-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(b);

(140) **Unfunded Pension Liabilities** means the unfunded pension liabilities of Seller's or its Wholly Owned Subsidiary's defined benefit pension plan, the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan, calculated as the Accumulated Benefit Obligation reduced by the fair market value of the assets of Seller's or its Wholly Owned Subsidiary's defined benefit pension plan and of the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan as of Closing, all as measured the actuaries currently engaged by such plans; *provided*, further, that when calculating the Accumulated Benefit Obligation for the Connecticut Health Care Associates Pension Plan, the actuary shall use a discount rate equal to seven and one-half percent (7.5%);

(141) **Unpaid Losses** is defined in Section 10.09;

(142) **WARN Act** is defined in Section 3.20(e);

(143) **WGCC** is defined in the recitals;

(144) **Wholly Owned Subsidiary** means, with respect to any Person, (i) any corporation 100% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Wholly Owned Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Wholly Owned Subsidiaries of such Person has a 100% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Wholly Owned Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (a) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (b) whose sole member is such Person; and

(145) **WMA** is defined in Section 2.01(v).

1.02. Certain References. As used in this Agreement:

(a) references to "*this Agreement*" mean this Agreement, as amended from time to time, and all Exhibits and Schedules attached to or referenced in this Agreement;

(b) references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Agreement, unless the context states or implies otherwise;

(c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

(d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

(e) references to "*partnerships*" include general and limited partnerships;

(f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Eastern Time;

(i) references to "*Seller's Knowledge,*" "*Knowledge of Seller*," or words of similar intent or effect mean and refer to (x) all matters with respect to which Seller or any of its Wholly Owned Subsidiaries has received written notice, and (y) the knowledge of each of the Persons whose names or titles are set forth on Schedule

1.02(i), after due inquiry by Seller (or Wholly Owned Subsidiary, as applicable) of such Persons;

(j) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(k) the Table of Contents, the division of this Agreement into Articles and Sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this Agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this Agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller and its Wholly Owned Subsidiaries in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

(a) all Owned Real Property, including the real property described on Schedule 2.01(a);

(b) all Leased Real Property, to the extent assignable or transferrable, including the real property described on Schedule 2.01(b);

(c) all of the tangible personal property owned or leased by Seller and its Wholly Owned Subsidiaries or used in the conduct of the Hospital Businesses, including all equipment (including medical and computer equipment located at the Hospital), vehicles, furniture and furnishings and other tangible personal properties, a current list and the general location of which are set forth on Schedule 2.01(c)(i); *provided* that any such leased personal property shall be described on Schedule 2.01(c)(ii);

(d) all current assets not otherwise specifically described above or below in this Section 2.01 that are included in Net Working Capital;

(e) to the extent transferable, all financial, patient, medical staff, personnel and other records of the Hospital Businesses, including, but not limited to, all documents, records, operating manuals, files, and computer software with respect to the operation of the Hospital Businesses, including, without limitation, all patient records, medical records, employee records, financial records, equipment records, construction plans and specifications, medical and administrative libraries, operating manuals, proprietary manuals, marketing materials, policy and procedure manuals, files, documents, records, books, catalogs, data, and studies or analyses;

(f) all rights and interest, to the extent assignable or transferable, with respect to the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), and the leases relating to the leased personal property listed or described on Schedule 2.01(c), and all

Immaterial Contracts not listed or described on Schedule 2.02(q) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits, to the extent legally assignable, including those Permits described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and all goodwill associated therewith, and the Information Systems;

(i) all property of Seller and its Wholly Owned Subsidiaries, real, personal or mixed, tangible or intangible, arising or acquired between the date of this Agreement and the Closing Date;

(j) all usable inventories of supplies, drugs, food, janitorial and office supplies, and other disposables and consumables located at the Hospital Businesses, or used with respect to the operation of the Hospital Businesses (the term "usable" in this clause meaning non-obsolete or slow moving and consumable within the ordinary course of business of the Hospital Businesses, consistent with past practices);

(k) all claims of Seller and its Wholly Owned Subsidiaries against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, except for those claims described on Schedule 2.02(n)[1] and any claims relating to Excluded Assets or the Excluded Liabilities;

(l) general intangibles of the Hospital Businesses, including goodwill;

(m) all advance payments, prepayments, prepaid expenses, deposits, and the like that were made with respect to the operation of the Hospital Businesses and have continuing value to the Hospital Businesses as of the Closing Date, the current categories and amounts of which are set forth on Schedule 2.01(m);

(n) Seller's and its Wholly Owned Subsidiaries' provider agreements with third-party payors, including, but not limited to, Government Payment Programs;

(o) the electronic funds transfer account of the Hospital Businesses (the "**EFT Account**") (other than any cash in such EFT Account at Closing, which shall be an Excluded Asset) and all information necessary to access the EFT Account;

(p) all other bank accounts that receive deposits from Government Payment Programs; *provided*, *however*, that all funds in such accounts as of the Closing Date shall be retained by Seller;

(q) all of Seller's stock, partnership, membership, or other ownership interests, to the extent assignable or transferable and not inconsistent with Legal Requirements, in each of the Joint Ventures and Converted Ventures (the "**JV**

[1] To be determined.

Interests"), but only to the extent that the governing instruments thereof and Legal Requirements permit such transfer, together with all minutes and other records relating to such entities that are in the possession of Seller as of the Closing Date; *provided*, *however*, that the JV Interests in Heart Center and WGCC shall not be conveyed to Seller at Closing and Seller shall dissolve Heart Center and WGCC at or prior to Closing; *provided*, *further*, that, notwithstanding the foregoing or anything to the contrary, Heart Center and WGCC shall constitute Joint Ventures, and the JV Interests in Heart Center and WGCC shall constitute Assets, as applicable, for the purposes of this Agreement;

(r) to the extent assignable by Seller, all warranties (express or implied) and rights and claims assertable by (but not against) Seller and its Wholly Owned Subsidiaries related to the Assets;

(s) all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or its Wholly Owned Subsidiaries or payable to Seller or its Wholly Owned Subsidiaries, and all deductibles, copayments and self-insurance requirements payable by Seller or its Wholly Owned Subsidiaries) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(t) all other property, other than the Excluded Assets, of every kind, character, or description owned by Seller or its Wholly Owned Subsidiaries, whether or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other businesses and ventures owned by Seller or its Wholly Owned Subsidiaries;

(u) the Investment interests of the Hospital in CAGW, including all transferable rights relating thereto, together with all minutes and other records relating to such entity that are in the possession of Seller or the Hospital as of the Closing Date;

(v) the Investment interests of the Hospital and GWMRI in Waterbury Medical Associates, L.L.P., a Connecticut limited liability partnership ("**WMA**"), including all transferable rights relating thereto, together with all minutes and other records relating to such entity that are in the possession of Seller, the Hospital or GWMRI as of the Closing Date;

(w) the Investment interests of the Hospital in Mattatuck Medical Associates, L.L.P., a Connecticut limited liability partnership ("**MMA**"), including all transferable rights relating thereto, together with all minutes and other records relating to such entity that are in the possession of Seller or the Hospital as of the Closing Date;

(x) [Intentionally omitted];

(y) all rights, claims, and choses in action of Seller described on Schedule 2.01(y) ("**CHA Claims**"), and any payments, awards, or other proceeds resulting therefrom; and

(z) all proceeds of the foregoing.

Seller shall convey good and marketable title to the Assets and all parts thereof to Buyer, free and clear of all claims, assessments, security interests, liens, restrictions, and encumbrances, other than the Permitted Encumbrances and the Assumed Liabilities.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in Section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this Agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

(a) all cash, cash equivalents, and short-term and long-term Investments, including cash in the EFT Account as of the Closing Date, but excluding the JV Interests transferred pursuant to Section 2.01;

(b) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and investments restricted as to use), trusts related to employee benefits, amounts reserved in connection with any unfunded Employee Benefit Plans listed in Section 3.21 that do not have a trust, trusts related to self-insurance, donor-restricted assets, beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(c) all intercompany receivables of Seller with any of its Affiliates or Wholly Owned Subsidiaries;

(d) all other current financial assets not included in Net Working Capital;

(e) any asset that would revert to the employer upon the termination of any of the Employee Benefit Plans, including assets representing a surplus or overfunding of any such plans;

(f) all rights to refunds, credits, deposits, prepayments, or the equivalent owing to Seller from any taxing authority with respect to periods prior to the Closing Date, and the right to pursue appeals of same;

(g) the taxpayer and other identification numbers, seals, minute books, corporate records, and other documents relating to the organization, maintenance, and existence of Seller and its Wholly Owned Subsidiaries;

(h) all claims, rights, interests, and proceeds (whether received in cash or by credit to amounts otherwise due to a third party) with respect to amounts overpaid with

respect to the Hospital Businesses to any third party with respect to periods prior to the Closing Date;

(i) all bank accounts relating to the Hospital Businesses, other than the EFT Account and any other account that receives payments from Government Payment Programs;

(j) all writings and other items that are protected from discovery by the attorney-client privilege, the attorney work product doctrine, or any other cognizable privilege or protection of Seller or its Wholly Owned Subsidiaries;

(k) any Cost Report settlement receivables of Seller or its Wholly Owned Subsidiaries for periods ended on or prior to the Closing Date;

(l) any assets owned and provided by vendors of goods or services to the Hospital Businesses, possession of which will be retained by the Hospital Businesses;

(m) unclaimed property of any third party in respect of the operation of the Hospital Businesses, including, without limitation, property that is subject to applicable escheat laws;

(n) all rights, claims, and choses in action of Seller against third parties in respect of the operation of the Hospital Businesses with respect to periods prior to the Closing Date described on Schedule 2.02(n), and any payments, awards, or other proceeds resulting therefrom, but excluding the CHA Claims (which, for the avoidance of doubt, constitute Assets in accordance with Section 2.01(y));

(o) all interests in, and assets related to, Children's Center of Greater Waterbury Health Network, Inc. and Healthcare Alliance Insurance Company, Ltd.;

(p) the name "Waterbury Hospital Foundation";

(q) all rights and interests of Seller in and to the commitments, contracts, leases, and agreements other than the Assumed Contracts, including the commitments, contracts, leases and agreements set forth on Schedule 2.02(q) (collectively, the "**Excluded Contracts**");

(r) all insurance proceeds with respect to the Assets (including insurance proceeds received by Seller or its Wholly Owned Subsidiary or payable to Seller or its Wholly Owned Subsidiary) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent all damage to the Assets has been repaired by Seller;

(s) the portions of inventory, prepaid expenses and the like, and other Assets disposed of, expended, or canceled, as the case may be, by the Hospital Businesses prior to the Closing Date in the ordinary course of business; and

(t) any other assets identified in Schedule 2.02(t).

2.03. Assumed Liabilities. In connection with the conveyance of the Assets to Buyer, Buyer shall assume, effective as of the Closing Date, the future payment and performance of the following liabilities (the "**Assumed Liabilities**") of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses:

(a) all obligations accruing after the Closing Date with respect to the Assumed Contracts or the Leased Personal Property;

(b) the trade accounts payable and current liabilities of the Hospital Businesses as of the Closing Date, but only to the extent such accounts payable and current liabilities are included in the calculation of Net Working Capital;

(c) obligations and liabilities as of the Closing Date in respect of accrued paid time off benefits of employees of Seller or its Wholly Owned Subsidiaries of the Hospital Businesses who are hired by Buyer as of the Closing Date, and related Taxes, but only to the extent such accrued paid time off benefits, and related taxes, are included in Net Working Capital;

(d) the Capital Lease Obligations described on Schedule 2.03(d);

(e) Tax liabilities or obligations in respect of the Hospital Businesses and the Assets with respect to periods commencing on or after the Closing Date;

(f) the Asbestos Abatement Liability;

(g) any liability owed or due and owing with respect to periods on or after the Closing Date with respect to any Employee Benefit Plan listed on Schedule 2.03(g); and

(h) claims or potential claims for medical malpractice or general liability relating to events that occurred or arose prior to the Closing Date, but which are made or asserted against any of the Hospital Businesses, Joint Ventures or Converted Ventures for the first time after the Closing Date and where such claim (or the circumstances' surrounding such claim) could not have been properly reported by such Hospital Businesses, Joint Ventures or Converted Ventures to their respective insurance carrier(s) on or prior to the Closing Date; *provided*, *however*, that Buyer may, at its option, undertake a loss portfolio transfer with respect to some or all of such liabilities.

Buyer shall not be liable for (i) any claims arising from Seller's or its Wholly Owned Subsidiaries' assignment and Buyer's assumption of the Assumed Liabilities; (ii) uncured defaults in the performance of the Assumed Liabilities for periods prior to the Closing Date; (iii) unpaid amounts in respect of the Assumed Liabilities that are due as of the Closing Date (that are not reflected in Net Working Capital or the Capital Lease Obligations); and/or (iv) rights or remedies claimed by third parties under any of the Assumed Liabilities that broaden or vary the rights and remedies such third parties would have had against Seller, its Wholly Owned Subsidiaries and the Hospital Businesses if the sale and purchase of the Assets were not to occur.

2.04. Excluded Liabilities. Except for the Assumed Liabilities, the Buyer shall not assume and under no circumstances shall the Buyer be obligated to pay or assume, and none of the assets of Buyer shall be or become liable for or subject to, any liability, indebtedness, commitment, or obligation of Seller or its Wholly Owned Subsidiaries, whether known or unknown, fixed or contingent, recorded or unrecorded, currently existing or hereafter arising or otherwise (collectively, the "**Excluded Liabilities**"), including, without limitation, the following Excluded Liabilities:

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

(b) claims or potential claims for medical malpractice or general liability relating to events that occurred or arose prior to the Closing Date, but which are made or asserted against any of the Hospital Businesses, Joint Ventures or Converted Ventures for the first time prior to the Closing Date, and any such claim made or asserted before or after the Closing Date, where such claim (or the circumstances surrounding such claim) could have properly been reported by such Hospital Businesses, Joint Ventures or Converted Ventures to their respective insurance carrier(s) on or prior to the Closing Date;

(c) those claims and obligations (if any) specified in Schedule 2.04 hereto;

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

(e) liabilities or obligations associated with indebtedness for borrowed money (other than Capital Lease Obligations);

(f) liabilities and obligations of Seller or its Wholly Owned Subsidiaries in respect of the Hospital Businesses with respect to periods prior to the Closing Date arising under the terms of Government Payment Programs or other third party payor programs, and any liability arising pursuant to Government Payment Programs or other third party payor programs as a result of the consummation of any of the transactions contemplated under this Agreement, including, for the avoidance of doubt, all Medicare and Medicaid Cost Reports, DSH payments or other settlements for all periods prior to the Closing Date, and including, but not limited to, those matters set forth on Schedule 3.05(a) and Schedule 3.05(b);

(g) Taxes incurred by the Hospital Businesses with respect to periods prior to the Closing Date (*provided*, *however*, that this clause (g) shall not apply to any and all Taxes payable with respect to any employee benefits constituting Assumed Liabilities under Section 2.03(c) hereof and any Taxes constituting Assumed Liabilities under Section 2.03(e) hereof);

(h) liability for any and all claims by or on behalf of employees of Seller or its Wholly Owned Subsidiaries relating to periods prior to the Closing Date, including, without limitation, liability for any pension, profit sharing, deferred compensation, or any other employee health and welfare benefit plans, liability for any Equal Employment Opportunity Commission claim, Americans with Disability Act claim,

Family and Medical Leave Act claim, wage and hour claim, unemployment compensation claim, or workers' compensation claim, and any liabilities or obligations to former employees of Seller or its Wholly Owned Subsidiaries under COBRA (*provided*, *however*, that this clause (i) shall not apply to any and all employee benefits constituting Assumed Liabilities under Section 2.03(g) hereof);

(i) any obligation or liability accruing, arising out of, or relating to any federal, state, or local investigations of, or claims or actions against, Seller or its Wholly Owned Subsidiaries, the Hospital Businesses, or any of their employees, medical staff, agents, vendors, or representatives with respect to acts or omissions prior to the Closing Date, including, but not limited to, with respect to those matters set forth on Schedule 3.05(a) and Schedule 3.05(b);

(j) any civil or criminal obligation or liability accruing, arising out of, or relating to any acts or omissions of Seller, its Wholly Owned Subsidiaries, or their directors, officers, employees, representatives, and agents claimed to violate any Legal Requirements of any Governmental Authority arising out of acts occurring before the Closing Date, including, but not limited to, with respect to those matters set forth on Schedule 3.05(a) and Schedule 3.05(b);

(k) liabilities or obligations arising as a result of any breach by Seller or its Wholly Owned Subsidiaries or the Hospital Businesses at any time of any Excluded Contract;

(l) liabilities or obligations arising out of any breach by Seller or its Wholly Owned Subsidiaries or the Facilities prior to the Closing Date of any Assumed Contract;

(m) any obligation or liability asserted under the federal Hill-Burton Act or other restricted grant and loan programs with respect to the ownership or operation of the Hospital Businesses or the Assets;

(n) any debt, obligation, expense, or liability of Seller or its Wholly Owned Subsidiaries arising out of or incurred solely as a result of any transaction occurring after the Closing Date or for any violation by Seller or its Wholly Owned Subsidiaries of any law, regulation, or ordinance at any time (including, without limitation, those pertaining to fraud, environmental, health care regulatory, and ERISA matters);

(o) all liabilities and obligations relating to any oral agreements, oral contracts, or oral understandings, including those with any referral sources, including, but not limited to, physicians, unless reduced to writing and expressly assumed as part of the Assumed Contracts;

(p) any liability arising out of the act of assignment of any of the Assumed Contracts to Buyer at the Closing;

(q) the obligations and liabilities arising in connection with the Transfer Act; and

(r) all workers' compensation liabilities of Seller and its Wholly Owned Subsidiaries.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and its Wholly Owned Subsidiaries and tender the purchase price, determined as follows (the "**Purchase Price**"), subject to the adjustments described in Section 2.05(g):

(i) $31,800,000, *plus*

(ii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds the Target Net Working Capital, or *minus*

(iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than the Target Net Working Capital, and *minus*

(iv) the amount of the Capitalized Lease Obligations in excess of $6,500,000, and *minus*

(v) the Unfunded Pension Liabilities, which shall be calculated as of the Closing Date, and *minus*

(vi) the Asbestos Abatement Liability, and *minus*

(vii) the amount of liabilities listed on Schedule 2.05(a)(vii).

(b) Notwithstanding the foregoing Section 2.05(a), no liabilities of Seller or its Wholly Owned Subsidiaries shall be subtracted from the Purchase Price to the extent any such liabilities are already included in Net Working Capital.

(c) The Purchase Price, including estimates at Closing of the Net Working Capital, the Unfunded Pension Liabilities and the Negative Amount, as applicable, will be calculated as follows.

(i) For purposes of determining the Purchase Price, not more than five (5) but in no event less than two (2) business days prior to the Closing, Seller shall deliver to Buyer a statement setting forth its good faith estimate as of the Closing Date of the (a) Net Working Capital, (b) Unfunded Pension Liabilities and (c) Negative Amount, as applicable, including supporting documentation of reasonable specificity and other information requested by the Buyer to verify such amounts.

(ii) The estimate of Net Working Capital at Closing will be calculated by Seller from the physical count of Seller's inventory that will be conducted five (5) business days prior to the Closing (it being agreed that Buyer shall have the

right to observe the physical count), the relevant entries in the Interim Closing Balance Sheets and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06. The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer.

(iii) The estimate of Unfunded Pension Liabilities at Closing will be calculated by Seller from the Interim Closing Balance Sheets and/or the then most recently updated actuarial analyses.

(d) At Closing, Buyer shall pay such Purchase Price (based on the estimate provided by Seller pursuant to Section 2.05(c)) by wire transfer of immediately available funds to an account designated by the Seller to Buyer prior to the Closing Date, and Seller shall immediately use whatever portion of the Purchase Price is necessary to pay off all indebtedness of Seller (other than Capitalized Lease Obligations assumed by Buyer), including the indebtedness under the Loan Agreement. Notwithstanding anything to the contrary set forth in this Agreement, in the event that the Purchase Price calculated in accordance with Section 2.05(c) or Section 2.05(e), as applicable, equals a negative number, the Purchase Price shall be deemed to equal zero, and Seller shall not be required to pay Buyer in cash with respect to such Negative Amount; *provided, however*, that the Capital Amount shall be reduced, in accordance with Section 1.01(24)(x), by an amount equal to the absolute value of such negative number (the "**Negative Amount**").

(e) Not more than ninety (90) days after the Closing, Buyer shall prepare and deliver, or cause to be prepared and delivered, to Seller, the final closing statement (the "**Final Closing Statement**") setting forth (i) its good faith determination of the actual Net Working Capital as of the Closing Date (based on the Closing Balance Sheets), (ii) a calculation showing the difference between the Net Working Capital estimated by Seller at Closing and the actual Net Working Capital as of the Closing Date, (iii) its good faith determination of the actual Unfunded Pension Liabilities as of the Closing Date (as determined by the actuaries then serving those pension plans), (iv) a calculation showing the difference between the Unfunded Pension Liabilities estimated by Seller at Closing and the actual Unfunded Pension Liabilities (as determined by the actuaries then serving those pension plans) as of the Closing Date, (v) its good faith determination of the actual Negative Amount as of the Closing Date, and (vi) a calculation showing the difference between the Negative Amount estimated by Seller at Closing and the actual Negative Amount as of the Closing Date. Except as otherwise provided herein, the Final Closing Statement and the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable, Unfunded Pension Liabilities, contractual allowances and doubtful accounts, as used in preparing the Audited Financial Statements, except as otherwise provided in this Agreement.

(f) Following receipt of the information set forth in Section 2.05(e), Seller will be afforded a period of twenty (20) business days (the "**20-Day Period**") to review the Final Closing Statement and the Closing Balance Sheets. At or before the end of the 20-Day Period, Seller will either (i) accept the amount of the actual Net Working Capital

and Unfunded Pension Liabilities calculated by Buyer in their entirety or (ii) deliver to Buyer a written notice (the "**Objection Notice**") containing a reasonably detailed written explanation of those items on the Final Closing Statement or the Closing Balance Sheets that Seller disputes, in which case the items specifically identified by Seller shall be deemed to be in dispute. The failure by Seller to deliver the Objection Notice within the 20-Day Period shall constitute Seller's acceptance of the amount of the actual Net Working Capital and Unfunded Pension Liabilities calculated by Buyer. If Seller delivers the Objection Notice in a timely manner, then, within a further period of twenty (20) business days from the end of the 20-Day Period (the "**Second 20-Day Period**"), the parties will attempt to resolve in good faith any disputed items and reach a written agreement (the "**Settlement Agreement**") with respect thereto. Failing such resolution, as promptly as practicable (and no event later than ten (10) business days from the end of the Second 20-Day Period), the unresolved disputed items will be referred for final binding resolution to Deloitte (the "**Arbitrating Accountants**"). In resolving any disputed item, the Arbitrating Accountants may not assign a value to any item greater than the greatest value for such item claimed by either party or less than the smallest value for such item claimed by either party. The fees and expenses of the Arbitrating Accountants shall be allocated between Buyer and Seller in proportion to the amounts by which their proposals of the actual Net Working Capital and Unfunded Pension Liabilities differed from the Arbitrating Accountants' final determination. Such determination (the "**Accountants' Determination**") shall be (i) in writing, (ii) furnished to the Buyer and Seller as soon as practicable (and in no event later than thirty (30) business days) after the items in dispute have been referred to the Arbitrating Accountants, (iii) made in accordance with GAAP, consistently applied, and (iv) non-appealable and incontestable by Buyer or Seller and each of their respective Affiliates and successors and assigns and not subject to collateral attack for any reason other than manifest error or fraud.

(g) The Purchase Price will be recalculated (based on clauses (i), (ii) and (iii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(c)(ii) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) estimated at Closing and the actual Net Working Capital as of the Closing Date (based on the Closing Balance Sheets), and (iii) the difference between the Unfunded Pension Liabilities estimated at Closing and the actual Unfunded Pension Liabilities (based on the Closing Balance Sheets).

(h) Within five (5) business days following the Final Determination Date, Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment and to the extent Seller has sufficient cash to make such payment), or Buyer shall pay the Seller (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient. If Seller is required to pay Buyer pursuant to this Section 2.05(h), but is unable to pay Buyer in full within five (5) business days following the Final Determination Date

(solely because Seller does not have sufficient cash), the Capital Amount shall be reduced, in accordance with Section 1.01(24), by an amount equal to such shortfall (the "**Purchase Price Adjustment Shortfall**"), subject to the proviso in Section 2.05(d).

2.06. Prorations. At Closing, and to the extent not included in Net Working Capital, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Person that is a non-profit corporation that does not pay any property Taxes with respect to such property) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer upon Buyer's receipt of such credit.

2.07. Disclaimer of Warranties. Subject to the representations and warranties set forth in this Agreement, including, but not limited to, those set forth in Article 3, and except as expressly set forth in the Closing Documents, the Assets transferred to the Company and any Buyer will be transferred in their physical condition at the Closing, "AS IS, WHERE IS, AND WITH ALL FAULTS AND NONCOMPLIANCE WITH LAWS," and with respect to the Real Property, land, buildings, and improvements, WITH NO WARRANTY OF HABITABILITY OR FITNESS FOR HABITATION, and with respect to the physical condition of the personal property and the inventory and supplies, WITH NO WARRANTIES, INCLUDING, WITHOUT LIMITATION, THE WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer and PMH on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Seller is a non-stock corporation duly organized and validly existing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct the Hospital Businesses as now being conducted, to enter into this Agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this Agreement and the Closing Documents to which Seller is or becomes a party, and the consummation by Seller of the transactions contemplated by this Agreement:

(a) are within its corporate powers, are not in contravention of law or of the terms of its organizational documents, and have been duly authorized by all appropriate corporate action;

(b) except as provided in Section 5.05 below, do not require any approval or consent of, or filing with, any Governmental Authority bearing on the validity of this Agreement that is required by Legal Requirements of any such Governmental Authority;

(c) except as set forth in Schedule 3.02(c), will neither conflict with, nor result in any breach or contravention of, or the creation of any lien, charge, or encumbrance under, or permit the acceleration of the maturity of, any indenture, agreement, lease, instrument, or understanding to which it is a party or by which it is bound, except for such breaches or contraventions that may result from the failure to obtain the consent of the counterparty thereto in connection with the assignment of any Assumed Contract to the Buyer and for which Seller remains liable;

(d) will not violate any material Legal Requirements of any Governmental Authority to which it or the Assets may be subject; and

(e) will not violate any judgment, decree, writ, or injunction of any court or Governmental Authority to which it or the Assets may be subject.

3.03. Binding Agreement. This Agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof.

3.04. Investments and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material assets, or any interest therein, of Seller, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Buyer with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance.

(a) Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.05(a) or as set forth on Schedule 3.05(a), the operations of the Hospital Businesses are in compliance in all material respects with all applicable Legal Requirements of Governmental Authorities having jurisdiction over the Hospital Businesses and the operations of the Hospital or its related ancillary services. Seller and its Wholly Owned Subsidiaries have timely filed all reports, data, and other information required to be filed with any Governmental Authorities. Neither Seller nor its Wholly Owned Subsidiaries, nor any of its officers, directors, agents, or employees thereof, has committed a violation of federal or state laws regulating health care fraud, including but not limited to the federal Anti-Kickback Law, 42 U.S.C. §1320a-7b, the Stark Laws, 42 U.S.C. §1395nn, as amended, and the False Claims Act, 31 U.S.C. §3729, et seq. Seller and its Wholly Owned Subsidiaries are in compliance in all material

respects with the administrative simplification provisions required under HIPAA, including the electronic data interchange regulations and the health care privacy regulations. Seller and its Wholly Owned Subsidiaries have not received notice of any claim, Proceeding, or investigation alleging or based upon an alleged material violation of any Legal Requirements.

(b) Seller has provided to Buyer a copy of the Hospital's current compliance program materials, including, without limitation, all program descriptions, compliance officer and committee descriptions, ethics and risk area policy materials, training and education materials, auditing and monitoring protocols, reporting mechanisms, and disciplinary policies. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.05(b) or to the extent set forth on Schedule 3.05(b), Seller (or any Wholly Owned Subsidiary thereof) (a) is not a party to a Corporate Integrity Agreement with the Office of Inspector General of the United States Department of Health and Human Services, (b) has no reporting or other continuing obligations pursuant to any settlement or other agreement entered into with any Government Authority (other than participation agreements with Government Payment Programs), (c) to the Knowledge of Seller, has not been the subject of any Government Payment Program investigation conducted by any federal or state enforcement agency within the past three (3) years, (d) has not been a defendant in any unsealed *qui tam*/False Claims Act litigation within the past three (3) years, (e) has not been served with or received, within the past three (3) years, any search warrant, subpoena, civil investigative demand, or contact letter by or from any Government Authority (except in connection with medical services provided to third parties who may be defendants or the subject of investigation into conduct unrelated to the operations of the health care businesses conducted by the Hospital Businesses), and (f) has not received any complaints within the past three (3) years from employees, independent contractors, vendors, physicians, or any other person that would indicate that Seller (or any Wholly Owned Subsidiary thereof) has violated any Legal Requirements. Schedule 3.05(b) includes a description of each audit and investigation conducted by Seller at the Hospital pursuant to its compliance program during the past three (3) years. For purposes of this Agreement, the term "compliance program" refers to provider programs of the type described in the compliance guidance published by the Office of Inspector General of the Department of Health and Human Services.

3.06. Financial Statements; Undisclosed Liabilities. Seller has delivered to Buyer copies of the following financial statements (collectively, the "**Financial Statements**"), which Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 3.06:

(a) Unaudited balance sheet dated as of June 30, 2016 (the "**Balance Sheet Date**");

(b) Unaudited income statement for the 9-month period ended on the Balance Sheet Date; and

(c) Audited Financial Statements.

Such unaudited Financial Statements conform to GAAP consistently applied, except as set forth on Schedule 3.06. Such audited Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such balance sheets present fairly the financial condition of Seller as of the dates indicated thereon, and such income statements included in the Financial Statements present fairly the results of operations of Seller for the periods indicated thereon. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses, Joint Ventures or Converted Ventures, or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in Financial Statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the Balance Sheet Date, and none of which could reasonably be expected to result, individually or in the aggregate, in a material adverse effect.

3.07. Recent Activities. Except as set forth in Schedule 3.07, with respect to Seller or its Wholly Owned Subsidiaries, since the Balance Sheet Date there has not been any:

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

(b) material adverse change in the condition, financial or otherwise, of the Hospital Businesses or the Assets, including, but not limited to, the business or prospects of the Hospital Businesses or the results of operations of the Hospital Businesses;

(c) threatened employee strike, material work stoppage, or material labor dispute pertaining to the Hospital Businesses;

(d) sale, assignment, transfer, or disposition of any item of property, plant, or equipment included in the Assets and having a net book value in excess of Seventy-Five Thousand Dollars ($75,000) (other than supplies), except in the ordinary course of business with comparable replacement thereof;

(e) sale, factor or disposition of, or agreement to sell, factor or dispose of, any accounts receivable;

(f) any general increase in the compensation payable to any of its or their employees or independent contractors or any increase in, or institution of, any bonus, severance, insurance, pension, profit-sharing or other employee benefit plan, remuneration, or arrangements made to, for, or with such employees;

(g) dividend, distribution, or extraordinary payment;

(h) change in the composition of the medical staff of the Hospital Businesses, other than normal turnover occurring in the ordinary course of business;

(i) change in the rates charged by the Hospital Businesses for their services, other than those made in the ordinary course of business;

(j) adjustment or write-off of accounts receivable or reduction in reserves for accounts receivable outside the ordinary course of business;

(k) change in the accounting methods or practices, including the methods used to estimate contractual allowances or doubtful accounts, other than those required by any changes in GAAP, or change in depreciation or amortization policies;

(l) encumbrance or lien that has been imposed on any of the Assets;

(m) cancellation or waiver of any material rights in respect of the Assets, except in the ordinary course of business;

(n) other than compensation paid in the ordinary course of employment, sale of any Assets to, or execution of any contract or agreement with, any officer, director or trustee of Seller, or with any Affiliate of any such person or entity;

(o) payment or agreement to pay to any Person any damages, fines, penalties or other amounts in excess of $25,000 individually or $100,000 in the aggregate in respect of an actual or alleged violation of any Legal Requirement; or

(p) transaction outside the ordinary course of business.

3.08. Accounts Receivable; Inventory.

(a) All Accounts Receivable constituting a part of the Assets represent and constitute bona fide indebtedness owing to Seller (or any Wholly Owned Subsidiary thereof) for services actually performed or for goods or supplies actually provided in the amounts indicated on the Financial Statements with no known Encumbrances, set-offs, deductions, compromises, or reductions (other than reasonable allowances for bad debts and contractual allowances in an amount consistent with historical policies and procedures of Seller and that are taken into consideration in the preparation of the Financial Statements). Seller has made available to Buyer a complete and accurate aging report of all such Accounts Receivable and a schedule of all Accounts Receivable that have been assigned to collection agencies or are otherwise held or assigned for collection.

(b) The inventory and supplies constituting part of the Assets are substantially of a quality and quantity usable and salable in the ordinary course of business of the Hospital Businesses. Obsolete items have been written off the Financial Statements. Inventory and supplies are carried at cost, on a first-in, first-out basis, and are properly stated in the Financial Statements in accordance with GAAP. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.09. Equipment. Seller has delivered to Buyer a fixed asset listing and depreciation schedule as of the Balance Sheet Date (Schedule 3.09) that takes into consideration all the equipment associated with, or constituting any part of, the Hospital Businesses and the Assets.

All major items of equipment are useable for their intended purpose in the ordinary course of business and are in working condition, subject to reasonable wear and tear.

3.10. Title. Except as provided in Schedule 3.10, Seller or its Wholly Owned Subsidiary, as applicable, owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Permitted Encumbrances and Assumed Liabilities.

3.11. Real Property.

(a) Seller or its Wholly Owned Subsidiary, as applicable, owns good and marketable fee simple and/or leasehold title, as the case may be, to the Real Property, together with all buildings, improvements, and component parts thereon and all appurtenances and rights thereto. The Real Property will be conveyed to the Buyer free and clear of any and all Encumbrances other than the Permitted Encumbrances set forth on Schedule 3.11(a).

(b) With respect to the Real Property, except as set forth in Schedule 3.11(b):

(i) Neither Seller nor any Wholly Owned Subsidiary has received during the past five (5) years written notice of a violation of any applicable Legal Requirement;

(ii) The Owned Real Property, and, to Seller's Knowledge, Leased Real Property, and its operation are in compliance in all material respects with all applicable zoning ordinances, and the consummation of the transactions contemplated herein will not result in a violation of any applicable zoning ordinance or the termination of any applicable zoning variance now existing, and the buildings and improvements constituting the Real Property comply in all material respects with all building codes;

(iii) The Owned Real Property and, to Seller's Knowledge, Leased Real Property, is subject to no easements, restrictions, ordinances, or other limitations on title that could make such property unusable for its current use or the title uninsurable or unmarketable or that materially restrict or impair the use, marketability, or insurability of the Real Property other than the Permitted Encumbrances;

(iv) All of the Owned Real Property, and, to Seller's Knowledge, Leased Real Property, currently in use for the operations of the Hospital Businesses is in compliance in all material respects with the applicable provisions of the Rehabilitation Act of 1973, Title III of the Americans with Disabilities Act, and the provisions of any comparable state statute relative to accessibility (these laws are referred to, collectively, as the "**Accessibility Laws**"), and there is no pending, noticed, or, to the Knowledge of Seller, threatened litigation, administrative action, or complaint (whether from a state, federal, or local government or from any other person, group, or entity) relating to compliance of any of the Real Property with the Accessibility Laws;

(v) There are no tenants or other persons or entities occupying any space in the Owned Real Property other than pursuant to tenant leases described in Schedule 3.11(b), and no tenants have paid rent in advance for more than one month and no rebate, concession, improvement credit or other tenant allowance of any nature is owed to any tenant, nor is any landlord improvement work required, except as disclosed in Schedule 3.11(b);

(vi) All material obligations of Seller or any Wholly Owned Subsidiary as landlord required to be performed under each of the tenant leases have been performed;

(vii) Attached to Schedule 3.11(b) is a "rent roll" that sets forth for those leases where Seller or any Wholly Owned Subsidiary in respect of the Hospital Businesses is landlord, which contains: (i) the names of then current tenants; (ii) the rental payments for the then current month under each of the leases; (iii) a list of all then delinquent rental payments; (iv) a list of all concessions granted to tenants; (v) a list of all tenant deposits and a description of any application thereof, and (vi) a list of all uncured material defaults under the leases known to Seller or its Wholly Owned Subsidiaries;

(viii) Seller or any Wholly Owned Subsidiary has not received written notice of condemnation or of any special assessment relating to any part of the Real Property, of any existing or proposed plans to modify or realign any street or highway, or any existing or proposed eminent domain proceeding by any Government Authority that would result in the taking of all or any part of the Real Property or that would adversely affect the current use of any part of the Real Property;

(ix) All permanent certificates of occupancy and all other material licenses, permits, authorizations, consents, certificates, and approvals required by all Government Authorities having jurisdiction and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions) have been issued for the Owned Real Property (and all individual items constituting the Owned Real Property), for their current uses, have been paid for, are in full force and effect, and will not be invalidated, violated, or otherwise adversely affected by the transfer of the Real Property to the Buyer; and

(x) To the Knowledge of Seller, water, sanitary sewer, storm sewer, drainage, electric, telephone, gas, and other public utility systems are available to the Real Property, as currently developed, and are directly connected to the lines and/or other facilities of the respective public authorities or utility companies providing such services or accepting such discharge, either adjacent to the Real Property or through easements or rights of way appurtenant to and forming a party of the Real Property; and, with respect to the Owned Real Property, to the Knowledge of Seller, such easements or rights-of-way have been fully granted, all charges therefor have been fully paid by Seller or its Wholly Owned Subsidiaries, and all charges for the aforesaid utility systems and the connection of the Owned

Real Property to such systems, including without limitation connections fees, "tie-in" charges, and other charges now or hereafter to become due and payable, have been fully paid by Seller or its Wholly Owned Subsidiaries; and the water and sanitary sewer service described above is supplied by public authority.

3.12. Environmental Laws. Except as set forth on Schedule 3.12 hereto, (i) the Owned Real Property is not subject to any material environmental hazards, risks, or liabilities, (ii) neither Seller or its Affiliates, nor its Wholly Owned Subsidiaries, is in material violation of any and all Legal Requirements pertaining to the protection of human health and safety or the environment (collectively, "**Environmental Laws**"), including, without limitation, the Comprehensive Environmental Response Compensation and Liability Act, as amended ("**CERCLA**"), the Resource Conservation and Recovery Act, as amended ("**RCRA**"), and the Atomic Energy Act of 1954, as amended ("**AEA**"), and (iii) neither Seller nor any Affiliate thereof has received notice alleging or asserting either a violation of any Environmental Law or an obligation to investigate, assess, remove, or remediate any property, including but not limited to the Owned Real Property, under or pursuant to any Environmental Law. Except as set forth on Schedule 3.12, to the Knowledge of Seller, no Hazardous Substances have been, and through the Closing Date will be, disposed of on or released or discharged from or onto, or threatened to be released from or onto, the Owned Real Property (including groundwater) by Seller, or to Seller's Knowledge, any third party, in violation of any applicable Environmental Law. Except as set forth on Schedule 3.12, neither Seller or its Wholly Owned Subsidiaries nor, to Seller's Knowledge, any prior owners, operators, or occupants of the Owned Real Property, have allowed any Hazardous Substances to be discharged, processed, or otherwise released on the Owned Real Property in a manner that is in violation of any Environmental Law, and Seller and its Wholly Owned Subsidiaries has complied in all material respects with all Environmental Laws applicable to any part of the Real Property. The Hospital Businesses contain asbestos-containing material. Schedule 3.12 lists numerous reports, correspondence, operation and maintenance manuals, and other documents related to the asbestos-containing materials. These documents do not individually or collectively constitute a comprehensive asbestos survey of the Hospital Businesses or the Owned Real Property. Without in any way limiting the generality of the foregoing, to the Knowledge of Seller: (i) all current or former underground storage tanks located on the Owned Real Property and information in Seller's possession relating to the capacity, uses, dates of installation, and contents of such tanks located on the Owned Real Property are identified in the environmental reports listed on Schedule 3.12; (ii) there are not now, nor have there ever been, any collection dumps, pits, and disposal facilities or surface impoundments located on the Owned Real Property for the containment of Hazardous Substances except as identified in Schedule 3.12; and (iii) all existing underground storage tanks have been maintained in material compliance with all Environmental Laws. Except as set forth on Schedule 3.12, Seller or its Wholly Owned Subsidiaries holds all material environmental permits required in connection with the use by Seller of the Real Property or the operation of the Hospital Businesses and, to the extent permitted by law, Seller shall cause such environmental permits to be transferred to the Buyer (with the Buyer's necessary cooperation and assistance), all of which, to Seller's Knowledge, are in good standing and are not subject to meritorious challenge. The representations and warranties made in this Section 3.12 are the exclusive representations and warranties of Seller relating to environmental matters and shall supersede any and all other Sections in this Agreement including, but not limited to, Sections 3.05, 3.11(a) and 3.15.

3.13. Intellectual Property; Information Systems. Schedule 3.13 lists and briefly describes all material Intellectual Properties currently owned or used by Seller or its Wholly Owned Subsidiaries. No proceedings have been instituted or are pending or, to the Knowledge of Seller, threatened that challenge the validity of the ownership or use by Seller or its Wholly Owned Subsidiaries of such Intellectual Properties. Neither Seller nor its Wholly Owned Subsidiaries have agreed to license to a third party any owned Intellectual Properties and have no Knowledge of the use or the infringement of any such owned Intellectual Properties by any other Person. Seller (or any Wholly Owned Subsidiary thereof) owns (or possesses adequate and enforceable licenses or other rights to use) all material Intellectual Properties and all material Information Systems used.

3.14. Insurance. Schedule 3.14 is an accurate schedule of the insurance policies or self-insurance funds maintained by Seller or its Wholly Owned Subsidiaries covering the ownership and operations of the Hospital Businesses and the Assets, including the type of insurance, policy numbers, identity of insurers, amounts, and coverage. Seller has provided to Buyer a copy of all such policies and endorsements thereto. All of such policies are in full force and effect with no premium arrearage. Seller or its Wholly Owned Subsidiary, or any Affiliates thereof, has given in a timely manner to its insurers all notices required to be given under its insurance policies with respect to all of the claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions. Seller and its Wholly Owned Subsidiaries have not (a) received any written notice or other communication from any such insurance company canceling or materially amending any of such insurance policies, and to the Knowledge of Seller, no such cancellation or amendment is threatened, or (b) failed to give any required notice or present any claim that is still outstanding under any of such policies with respect to the Hospital Businesses or any of the Assets.

3.15. Permits. Each of the Hospital Businesses is duly licensed pursuant to the applicable laws of the State of Connecticut. The pharmacies, laboratories, and all other ancillary departments located at the Hospital Businesses or operated for the benefit of the Hospital Businesses that are required to be specially licensed are duly licensed by the Connecticut Department of Public Health or other appropriate licensing agency (the "**State Health Agency**"). Seller and its Wholly Owned Subsidiaries have all material Permits that are needed or required by law to operate the business related to or affecting the Hospital Businesses or any ancillary services related thereto. Seller has delivered to Buyer an accurate list and summary description (Schedule 2.01(g)) of all such Permits owned or held by Seller or its Wholly Owned Subsidiaries relating to the ownership, development, or operation of the Hospital Businesses or the Assets, all of which are now and as of the Closing shall be in good standing, except as disclosed on Schedule 3.15. Seller and its Wholly Owned Subsidiaries have not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any Permits relating to the Hospital Businesses or any ancillary services related thereto.

3.16. Government Payment Programs; Accreditation; Payor Cost Reports.

(a) The Hospital is qualified for participation in the Government Payment Programs, has a current and valid provider contract with such programs, is in compliance with the conditions of participation in such programs, and has received all

approvals or qualifications necessary for reimbursement for the Hospital. The Hospital is duly accredited, with no contingencies, by The Joint Commission (the "**Joint Commission**") for the three (3) year period set forth on Schedule 3.16(a). A copy of the most recent accreditation letter from the Joint Commission pertaining to the Hospital has been made available to Buyer. Seller has delivered to Buyer copies of all available accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction since July 31, 2016. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein. The billing practices employed by the Hospital Businesses with respect to all third party payors, including Government Payment Programs and private insurance companies, have been in compliance in all material respects with all applicable laws, regulations, and policies of the Government Payment Programs and applicable Contracts of such private insurance companies. Neither Seller nor its Wholly Owned Subsidiaries has billed or received any payment or reimbursement from any such payors in excess of amounts allowed by law or contract. Neither Seller nor any of its Affiliates, officers, directors, managers, employees, or controlling shareholders is excluded from participation in the Government Payment Programs, nor has Seller or any of its Wholly Owned Subsidiaries received any notice that any such exclusion is threatened. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.16 or as set forth on Schedule 3.16(a), neither Seller nor its Wholly Owned Subsidiaries has received any notice from any of the Government Payment Programs or any other third party payor programs of any pending or threatened investigations or surveys, and, to the Knowledge of Seller, no such investigations or surveys are pending, threatened, or imminent. Seller has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to the Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made in accordance with applicable reporting deadlines and in the form and manner required by CMS and the Joint Commission, respectively. Seller has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired.

(b) Seller, or its Wholly Owned Subsidiary, has duly filed all required Cost Reports in respect of the Hospital Businesses for all the fiscal years through and including the fiscal year ended September 30, 2014. All amounts shown as due from Seller (or any Wholly Owned Subsidiaries thereof) in such Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. All of such Cost Reports accurately reflect the information required to be included thereon and such Cost Reports do not claim and neither the Hospital Businesses nor Seller (or any Wholly Owned Subsidiaries thereof) has

received reimbursement in any amount in excess of the amounts provided by law or any applicable agreement. Schedule 3.16(b) indicates which of such Cost Reports have not been audited and finally settled and a brief description of any and all notices of program reimbursement, proposed or pending audit adjustments, disallowances, appeals of disallowances, and any and all other unresolved claims or disputes in respect of such Cost Reports. Seller or its Wholly Owned Subsidiary has established adequate reserves in respect of the Hospital Businesses to cover any potential reimbursement obligations that may exist in respect of any such third party Cost Reports, and such reserves are set forth in the Financial Statements.

3.17. Agreements and Commitments. Schedule 2.01(f) sets forth the Assumed Contracts that will be assumed by the Buyer. Seller has also delivered to Buyer an accurate list (Schedule 3.17) of all material Contracts that materially affect the Hospital Businesses or the Assets, to which Seller or its Wholly Owned Subsidiary is a party or by which Seller, its Wholly Owned Subsidiaries, the Assets, or any portion thereof, is bound, including, without limitation, (a) physician agreements, professional service agreements or co-management agreements, (b) agreements with health maintenance organizations, preferred provider organizations, independent practice associations, accountable care organizations, or other alternative delivery systems, (c) joint venture or partnership agreements, (d) employment, severance or retention Contracts or any other Contracts to or with individual employees or agents, including with directors, trustees, officers, employees, or other agents of Seller or its Wholly Owned Subsidiaries, (e) Contracts materially affecting ownership of, title to, use of, or any interest in Owned Real Property or Leased Real Property, (f) equipment leases and other leases that are capital leases, (g) equipment maintenance agreements, (h) agreements with Governmental Authorities, (i) collective bargaining agreements or other Contracts to or with any labor unions, labor organizations, or other employee representatives or groups of employees, (j) loan agreements, bonds, mortgages, liens, or other security agreements, (k) Contracts relating to Intellectual Properties and Information Systems, or other like Contracts affecting the Hospital Businesses or the Assets, (l) Contracts providing for payments based in any manner on the revenues or profits of Seller or any Wholly Owned Subsidiary thereof, the Hospital Businesses or the Assets, (m) Contracts relating to data processing programs, software, or source codes utilized in connection with the Hospital Businesses or the Assets, (n) Contracts relating to the administration, operation or funding of any Employee Benefit Plan, and (o) Contracts, whether in the ordinary course of business or not, that involve future payments, performance of services, or delivery of goods or material, to or by Seller (or any of its Wholly Owned Subsidiaries), of any amount or value in excess of Fifty Thousand Dollars ($50,000) on an annual basis.

3.18. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f), Seller has made available to Buyer true and correct copies of the Assumed Contracts, and has given, and will give, the agents, employees, and representatives of Buyer access to the originals of the Assumed Contracts in its possession. Seller represents and warrants with respect to the Assumed Contracts that:

(a) The Assumed Contracts constitute valid and legally binding obligations of Seller or a Wholly Owned Subsidiary and are enforceable against Seller or such Wholly Owned Subsidiary in accordance with their terms;

(b) Each Assumed Contract constitutes the entire agreement by and between the respective parties thereto with respect to the subject matter thereof;

(c) All obligations required to be performed by Seller or its Wholly Owned Subsidiary under the terms of the Assumed Contracts have been performed, no material breach has occurred under any of the Assumed Contracts, no act or omission by Seller or its Wholly Owned Subsidiary has occurred or failed to occur that, with the giving of notice, the lapse of time, or both would constitute a material default under the Assumed Contracts, and each of such Assumed Contracts is now in full force and effect;

(d) Except as expressly set forth on Schedule 3.18, none of the Assumed Contracts requires consent to the assignment and assumption of such Contracts by Buyer;

(e) Except as expressly set forth on Schedule 3.18, the assignment of the Assumed Contracts to and assumption of such Assumed Contracts by Buyer will not result in any penalty or premium, or variation of the rights, remedies, benefits, or obligations of any party thereunder; and

(f) Except as expressly set forth on Schedule 3.18, no Assumed Contract contains a prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing.

3.19. Transactions with Affiliates. Since September 30, 2014, Seller (or any Wholly Owned Subsidiary thereof) has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller, except as set forth on Schedule 3.19 or upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.20. Employees and Employee Relations.

(a) Except as set forth on Schedule 3.20(a), all employees of the Hospital Businesses are employees of Seller or its Wholly Owned Subsidiaries, and there has not been in the last three (3) years, there is not presently pending, there is not presently threatened (to the Knowledge of Seller), and no event has occurred or circumstance exists (to the Knowledge of Seller) that could provide the basis for, (i) any strike, slowdown, picketing, work stoppage, or employee grievance process, or (ii) any proceeding against or affecting Seller or its Wholly Owned Subsidiaries relating to an alleged violation of any Legal Requirements pertaining to labor relations, including, without limitation, any charge, complaint, or unfair labor practices claim filed by an employee, union, or other person with the National Labor Relations Board or any comparable Governmental Authority, organizational activity, or other labor dispute against or affecting Seller, its Wholly Owned Subsidiaries, the Hospital Businesses, or their premises.

(b) Except as set forth in Schedule 3.20(b), with respect to the employees of Seller or its Wholly Owned Subsidiaries: (i) no collective bargaining agreement exists or is currently being negotiated by Seller or its Wholly Owned Subsidiaries; (ii) no application for certification of a collective bargaining agent is pending; (iii) no demand has been made upon Seller or its Wholly Owned Subsidiaries for recognition by a labor organization; (iv) no union representation question exists; (v) no union organizing activities are, to the Knowledge of Seller, taking place; and (vi) none of the employees of Seller or its Wholly Owned Subsidiaries is represented by any labor union or organization.

(c) Except as set forth in Schedule 3.20(c), Seller and its Wholly Owned Subsidiaries have complied in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; neither Seller, nor its Wholly Owned Subsidiaries, are liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the Knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other entity), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other entity), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.20(d) (or as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.20(d)) states the number of employees terminated by Seller or any of its Wholly Owned Subsidiaries within ninety (90) days prior to the Closing Date, laid off by Seller or any of its Wholly Owned Subsidiaries within the six (6) months prior to the Closing Date, or whose hours of work have been reduced by more than fifty percent (50%) by Seller or any of its Wholly Owned Subsidiaries in the six (6) months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours; (ii) the reason for termination, layoff, or reduction in work hours; and (iii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.20(d), neither Seller, nor its Wholly Owned Subsidiaries, has violated the Worker Adjustment and Retraining Notification Act ("**WARN Act**") or any similar state or local Legal Requirements.

(e) To the Knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller or any of its Wholly Owned Subsidiaries is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the Hospital Businesses; or (ii) to assign to Seller or to any other Person any rights to any invention, improvement, or discovery. To the Knowledge of Seller, no former or

current employee of Seller or any of its Wholly Owned Subsidiaries at the Hospital Businesses is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as heretofore carried on by Seller prior to Closing.

(f) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller, its Wholly Owned Subsidiaries or the Hospital Businesses requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To the Knowledge of Seller, no employee of Seller, its Wholly Owned Subsidiaries or the Hospital Businesses who is a foreign national has ever worked without employment authorization from the Department of Homeland Security or any other Governmental Authority that must authorize such employment and Seller have complied with applicable immigration laws with respect to the employment of foreign nationals. To the Knowledge of Seller, Seller and its Wholly Owned Subsidiaries have timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no proceedings pending or, to Seller's Knowledge, threatened against Seller or any of its Wholly Owned Subsidiaries relating to Seller's or any Wholly Owned Subsidiary's compliance with federal immigration regulations, including compliance with federal immigration laws. Except as set forth on Schedule 3.20(f), neither Seller, nor any of its Wholly Owned Subsidiaries, has received any letter from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and neither Seller, nor any of its Wholly Owned Subsidiaries, has received any letter or other correspondence from the Department of Homeland Security or other Government Authority regarding the employment authorization of any employees of Seller or its Wholly Owned Subsidiaries. If Seller or any of its Wholly Owned Subsidiaries operates in a state or has Contracts with a Governmental Authority that requires or provides a safe harbor if an employer participates in the Department of Homeland Security's e-Verify electronic employment verification system, Seller or any of its Wholly Owned Subsidiaries, as applicable, has been participating in e-Verify for the entire period such participation has been required or available as a safe harbor or as long as Seller or any such Wholly Owned Subsidiary has been operating in such state or contracting with such Governmental Authority.

(g) To the Knowledge of Seller, all employees, former employees and independent contractors of Seller or its Wholly Owned Subsidiaries have been properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state law equivalent.

3.21. Employee Benefit Plans.

(a) Schedule 3.21(a) contains a list of all benefit plans maintained by Seller and its Wholly Owned Subsidiaries within the last five (5) years with respect to its employees (whether tax-qualified or nonqualified, currently effective or terminated, written or unwritten) including, without limitation, any of the following:

(i) employee pension benefit plan (as defined in Section 3(2) of ERISA), including, without limitation, any pension, profit-sharing, or stock bonus plan (as described in Section 401(a) of the Code, and related provisions thereof), defined benefit plan or defined contribution plan (as defined in ERISA Sections 3(34) and 3(35)), governmental plan, or church plan;

(ii) annuity contracts purchased by Seller or its Wholly Owned Subsidiaries for employees of the Hospital Businesses in accordance with Code Section 403(b) including, without limitation, any group annuity contracts, individual annuity contracts, and custodial account arrangements under Code Section 403(b)(7), regardless of whether contributions are made to such annuity contracts on a pre-tax or after-tax basis;

(iii) employee welfare benefit plan (as defined in ERISA Section 3(1)) including, without limitation, any health (including, without limitation, medical, dental, or vision) plan, life-insurance plan, death benefit plan, short-term disability plan, long-term disability plan, accident plan, accidental death and dismemberment plan, long-term care plan, or employee assistance plan;

(iv) fringe benefit plan, including, without limitation, any specified fringe benefit plan (as defined in Code Section 6039D), cafeteria plan, or tuition assistance plan;

(v) executive compensation or incentive plan, including, without limitation, any bonus plan, incentive-compensation plan, deferred-compensation plan, non-qualified profit-sharing plan, stock-option plan, stock-appreciation-right plan, stock-bonus plan, stock-purchase plan, employee-stock-ownership plan, or savings plan;

(vi) post-termination benefits plan including, without limitation, any severance plan, change-in-control plan, supplemental-unemployment plan, layoff plan, salary-continuation plan, or non-qualified retirement plan; or

(vii) vacation, holiday, sick-leave, paid-time-off, or other employee compensation plan, procedure, program, payroll practice, policy, agreement, commitment, contract, or understanding;

and any such plan or other arrangement that (i) is maintained or contributed to by Seller or any other corporation or trade or business controlled by, controlling, or under common control with Seller (within the meaning of Code Section 414 or ERISA Sections 4001(a)(14) or 4001(b)) ("**ERISA Affiliate**"), or with respect to which Seller or any ERISA Affiliate has or may have any liability; or (ii) provides benefits, or describes a plan, procedure, program, payroll practice, policy,

agreement, commitment, contract, or understanding applicable to any current or former director, officer, employee, or individual service provider of Seller or any ERISA Affiliate, or the dependents of any thereof, regardless of how (or whether) liabilities for the provision of benefits are accrued or assets are acquired or dedicated with respect to the funding thereof. All such plans or arrangements that are set forth on Schedule 3.21(a) are referred to hereinafter collectively as the "**Employee Benefit Plans**."

(b) Seller has delivered to Buyer accurate and complete copies of (i) the current documents comprising each Employee Benefit Plan (or, with respect to any Employee Benefit Plan that is unwritten, a detailed written description thereof); (ii) all current trust agreements or other funding instruments related to each Employee Benefit Plan, if any; (iii) all formal rulings, letters, and opinions regarding each Employee Benefit Plan from the IRS, the DOL, PBGC, or any other Governmental Authority that pertains to each Employee Benefit Plan that have been issued within the last three (3) years and any open requests therefor; (iv) the annual reports filed with any Governmental Authority with respect to each Employee Benefit Plan during the current year and each of the three (3) preceding years, if any; (v) all current contracts with third-party administrators, consultants, and other independent contractors that relate to each Employee Benefit Plan; (vi) all current summary plan descriptions, summaries of material modifications and memoranda, and other written communications regarding each Employee Benefit Plan currently in effect, if applicable; and (vii) documents evidencing compliance with the privacy requirements under HIPAA relating to each Employee Benefit Plan, as to which such requirements apply.

(c) Except as provided on Schedule 3.21(c):

(i) Each Employee Benefit Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with all applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Employee Benefit Plan and applicable Legal Requirements;

(ii) Neither Seller nor any ERISA Affiliate has any material liability under any Employee Benefit Plan for which Buyer has or will have any liability (other than liability for any regular annual contributions required under such Employee Benefit Plans), contingent or otherwise, under Titles I or IV of ERISA or the Code, including, without limitation, any liability with respect to any "multiemployer plan" (as defined in ERISA Sections 3(37)(A) or Section 4001(a)(3) or Code Section 414(f) ("**Multiemployer Plan**"), multiple employer plan (as described in Code Section 413(c)), or "single-employer plan" (as defined in ERISA Section 4001(a)(15)), whether or not terminated; self-insured or self-funded "multiple employer welfare arrangement" as such term is defined in ERISA Section 3(40); prohibited transaction (pursuant to Code Section 4975 or ERISA Section 406) with any Employee Benefit Plan that is not subject to an exemption under Code Section 4975 or ERISA Section 408 or the regulations

thereto; excise tax or penalty imposed under ERISA or the Code with respect to any Employee Benefit Plan; or breach of any responsibilities or obligations imposed upon fiduciaries by Title I of ERISA with respect to any Employee Benefit Plan.

(iii) Each Employee Benefit Plan that is an "employee pension benefit plan" as defined in ERISA Section 3(2) other than a Multiemployer Plan and each related trust agreement, annuity contract, or other funding instrument is and has been since its inception intended to be qualified and tax-exempt under the provisions of Code Sections 401(a) and 501(a), or, if applicable, Code Section 403(b), and, for each such Employee Benefit Plan that is not stated on a master and prototype and/or volume submitter plan on which reliance is and can be based on a favorable opinion or advisory letter without the adopting employer having requested an individual determination letter, has been determined by the IRS pursuant to an individual favorable determination letter to be so qualified and tax-exempt or an application for such determination has been made and is currently pending; has not participated in any voluntary compliance or self-correction programs established by the IRS (or the DOL with respect to any fiduciary issues), or entered into a closing agreement with the IRS with respect to the form or operation of any Employee Benefit Plan within the six (6) years preceding the Closing Date; does not have and during the six (6) years preceding the Closing Date has not had any "unfunded accrued liability," as such term is defined under ERISA Section 3(30); has not experienced any "reportable events," as such term is defined under ERISA Section 4043, for which a waiver has not been granted; has not had any "accumulated funding deficiencies," as such term is defined under ERISA Section 302(a)(2) (prior to amendment by P.L. 109-280) or Code Sections 412(a) or 4971 (whether or not waived), nor for years after amendment by P.L. 109-280 any "funding shortfalls" as defined in Code Section 430(c); does not have any liabilities required to be disclosed on any annual report (Form 5500 series) that have not been disclosed; and has not been terminated.

(iv) With respect to each Employee Benefit Plan that is not an "employee pension benefit plan," as defined in ERISA Section 3(2), such plan may be terminated at the time of Closing according to its terms without any prior notice; no commitments have been made to provide lifetime or retiree benefits under any such plan; and no persons have any vested rights under any such plan.

(v) Each Employee Benefit Plan that is a "group health plan," as defined in ERISA Section 607(1) or Code Section 5000(b)(1), and that is maintained by Seller or any ERISA Affiliate has been operated at all times during the six (6) years preceding the Closing Date in material compliance with ERISA, to the extent applicable, the Code, the Social Security Act, and HIPAA.

(vi) All required contributions to all Employee Benefit Plans and all premiums, fees, or other payments required to be made by Seller or any ERISA Affiliate in connection with any Employee Benefit Plan have either been timely made or are reflected in the financial statements on an accrual basis. All returns,

reports, and disclosure statements required to be made under the Code, ERISA, to the extent applicable, or other applicable law with respect to the Employee Benefit Plans other than a Multiemployer Plan have been timely filed or delivered.

(vii) No Employee Benefit Plan is currently or has been within the last three (3) years under audit, inquiry, or investigation by the IRS, DOL, or PBGC, and there are no outstanding issues with reference to such Employee Benefit Plans pending before any governmental agency. Other than routine claims for benefits, there are no actions, mediations, audits, arbitrations, suits, claims, or investigations pending, or to the Knowledge of Seller or any ERISA Affiliate, threatened against or with respect to any of the Employee Benefit Plans sponsored by Seller or any ERISA Affiliate or their assets, and there are no threatened or pending claims by or on behalf of such Employee Benefit Plans or by any employee of Seller or any ERISA Affiliate 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 either Seller, any ERISA Affiliate or such Employee Benefit Plans under any law, nor is there any basis for such a claim.

(viii) Seller and its Wholly Owned Subsidiaries do not have any contracts, agreements, plans, or arrangements under which the contemplated transaction will result in any (i) payments (whether of separation pay or otherwise) becoming due from Seller or any ERISA Affiliate to any current or former employee, director, or consultant, or (ii) vesting, acceleration of payment, or increase in the amount of any benefit payable to or in respect of any such current or former employee, director, or consultant of Seller or any ERISA Affiliate that will, in turn, result in any liability to Buyer.

3.22. Proceedings and Legal Claims. Seller has delivered to Buyer an accurate list and summary description (Schedule 3.22) of all pending or, to the Knowledge of Seller, threatened Proceedings and legal claims with respect to the Seller, each Wholly Owned Subsidiary, the Hospital Businesses, and the Assets. Neither Seller nor any Wholly Owned Subsidiary is in default under any order of any Governmental Authority wherever located. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.22 or as set forth on Schedule 3.22, there are no claims, Proceedings, or investigations pending or, to the Knowledge of Seller, threatened against the Seller, any Wholly Owned Subsidiary, the Hospital Businesses or the Assets, at law or in equity, or before or by any Governmental Authority wherever located. With respect to insured claims, no carrier has issued a "reservation of rights" letter or otherwise denied its obligation to insure and defend Seller, or any of its Wholly Owned Subsidiaries, against covered losses arising therefrom.

3.23. Taxes.

(a) Seller and its Wholly Owned Subsidiaries have filed on a timely basis, or validly extended the time for filing, all federal, state, and local Tax Returns. All Tax Returns are true and correct in all material respects and accurately reflect in all material respects the Tax liabilities of Seller and its Wholly Owned Subsidiaries. All

amounts shown due on the Tax Returns have been or will be paid on a timely basis (including any interest or penalties and amounts due state unemployment authorities) to the appropriate tax authorities.

(b) Seller and its Wholly Owned Subsidiaries, as applicable, have withheld all proper amounts from the compensation of its employees in compliance with all withholding and similar provisions of the Code, including employee withholding and social security taxes, and any and all other applicable laws. All such amounts have been duly and validly remitted to the proper taxing authority. Further, Seller and its Wholly Owned Subsidiaries have withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by them to independent contractors, creditors and other Persons for which withholding or payment is required by applicable Legal Requirements.

(c) No deficiencies for any Taxes relating to the Seller or its Wholly Owned Subsidiaries have been asserted or, to the Knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the Knowledge of Seller, threatened. There are no outstanding agreements by Seller or its Wholly Owned Subsidiaries for the extension of time for the assessment of any Taxes. Seller and its Wholly Owned Subsidiaries have not taken any action in respect of any Taxes that may have a material adverse effect upon the Hospital Businesses or the Assets as of or subsequent to Closing.

(d) To Seller's knowledge, no Government Authority intends to assess any additional Taxes for any period for which Tax Returns have been filed. No claim has ever been made by a Government Authority in a jurisdiction where Seller or any Wholly Owned Subsidiary does not file Tax Returns that such entity is or may be subject to Tax in that jurisdiction. Neither Seller nor any of its Wholly Owned Subsidiaries has received written notice of Tax liens on any of the Assets.

(e) Seller is not a party to any Tax allocation or sharing contract. Seller is not, and has not been, a member of any affiliated group within the meaning of Section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law filing a consolidated federal income Tax Return.

(f) Each of Seller and its Wholly Owned Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the IRS and the State of Connecticut regarding such Tax status and nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption.

(g) Neither Seller, nor its Wholly Owned Subsidiaries, has any liability for the Taxes of any other person or entity (other than a subsidiary under IRS regulation 1.1502-6), as a transferee or successor, by contract or otherwise.

3.24. Medical Staff; Physician Relations. Seller has provided to Buyer true, correct, and complete copies of the bylaws and rules and regulations of the medical staff of the Hospital,

as well as a list of all current members of the medical staff. Except as set forth in Schedule 3.24, there are no adverse actions with respect to any medical staff members of the Hospital or any applicant thereto for which a medical staff member or applicant has requested a judicial review hearing that has not been scheduled or has been scheduled but has not been completed, and there are no pending or, to the Knowledge of Seller, threatened disputes with applicants, staff members, or health professional affiliates, and Seller knows of no basis therefor, and all appeal periods in respect of any medical staff member or applicant against whom an adverse action has been taken have expired. No member of the medical staff of the Hospital has been excluded from participation in any Government Payment Program.

3.25. Restricted Assets. Except as set forth on Schedule 3.25 hereto, neither Seller, its Wholly Owned Subsidiaries nor any of their predecessors has received any loans, grants, or loan guarantees pursuant to the Hill-Burton Act program, the Health Professions Educational Assistance Act, the Nurse Training Act, the National Health Planning and Resources Development Act, and the Community Mental Health Centers Act, as amended, or similar laws or acts relating to health care facilities. The transactions contemplated hereby will not result in any obligation on Buyer or any of its Affiliates to repay any of such loans, grants, or loan guarantees, nor subject Buyer, its Affiliates, or the Assets to any lien, restriction, or obligation, including any requirement to provide uncompensated care.

3.26. Brokers and Finders. Except for Cain Brothers, which is representing Seller, neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.27. Payments. None of the Hospital Businesses has, to Seller's Knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Neither Seller nor any of its Wholly Owned Subsidiaries has, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor any of its Wholly Owned Subsidiaries, nor to Seller's Knowledge, any officer, director or trustee of Seller or any Wholly Owned Subsidiary has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom Seller or any Wholly Owned Subsidiary conducts or has conducted any of the Hospital Businesses.

3.28. Joint Ventures.

(a) Schedule 3.28 sets forth for each Joint Venture, and as of the Closing Date, also for each Converted Venture: (i) its name and jurisdiction of incorporation or organization; (ii) the number of authorized shares of each class of its capital stock or other equity or non-equity interests; (iii) the number of issued and outstanding shares of each class of its capital stock or other equity or non-equity interests, the names of the holders thereof, and the number of shares or other equity or non-equity interests held by each such holder; (iv) the number of shares of its capital stock or other equity

interests held in treasury; and (v) its directors and officers, general partners, or managers, as the case may be. Seller does not hold any equity interest in any entity other than its Wholly Owned Subsidiaries and the Joint Ventures, and as of the Closing Date, the Converted Ventures.

(b) Subject to Section 5.19, each Joint Venture: (i) if it is a for profit or nonprofit corporation, is duly incorporated and validly existing under the laws of the state of its incorporation and is duly qualified and in good standing as a foreign corporation in the jurisdiction of its principal place of business if not incorporated therein; (ii) if it is a limited liability company, is duly organized, validly existing, and, if applicable, in good standing under the laws of the state of its organization and is duly qualified and, if applicable, in good standing as a foreign limited liability company in the jurisdiction of its principal place of business if not organized therein; and (iii) if it is a partnership, trust, or other entity, is duly formed, validly existing, and, if applicable, in good standing in the jurisdiction of its principal place of business if not formed therein. To the Knowledge of Seller, each Joint Venture, and as of the Closing Date, each Converted Venture, has full corporate, limited liability company, partnership, trust, or other applicable power and authority and all licenses and permits (including authorizations to do business in any applicable state) necessary to carry on the businesses in which it is engaged and in which it presently proposes to engage, and to own and use the properties owned and used by it. To the Knowledge of Seller, each Joint Venture, and as of the Closing Date, each Converted Venture, has not materially violated any Legal Requirement or material Contract or agreement.

(c) Seller has delivered to Buyer accurate and complete copies, as applicable, of the articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholder or membership agreement, as amended to date and in its possession, of each Joint Venture, and as of the Closing date, of each Converted Venture. Except as set forth on Schedule 3.28 hereto, all of the issued and outstanding shares of capital stock or other equity or non-equity interests of each Joint Venture, and as of the Closing Date, of each Converted Venture, that have been issued to Seller (or any Wholly Owned Subsidiary thereof) have been duly authorized and are validly issued, fully paid, and nonassessable. To the Knowledge of Seller, none of the Joint Ventures, and as of the Closing Date, none of the Converted Ventures, is in default under or in violation of any provision of its articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholders or membership agreement.

(d) Except as set forth in Schedule 3.28, to the Knowledge of Seller, (i) there is no outstanding subscription, option, convertible or exchangeable security, preemptive right, warrant, call, or agreement (other than this Agreement) relating to the stock or other equity or non-equity interests of the Joint Ventures, and as of the Closing Date, the Converted Ventures, or other obligation or commitment of any Joint Venture, and as of the Closing Date, of any Converted Ventures, to issue any shares of capital stock or other equity interests; and (ii) there are no voting trusts or other agreements, arrangements, or understandings applicable to the exercise of voting or any other rights with respect to any shares of Joint Venture stock or other equity or

non-equity interests, and as of the Closing Date, to any shares of Converted Venture stock or other equity or non-equity interests. Seller (or any Wholly Owned Subsidiary thereof) has good, marketable, and indefeasible title to all shares of the stock or other equity or non-equity interests of the Joint Ventures, and as of the Closing Date, of the Converted Ventures, set forth in Schedule 3.28 and, except as set forth on Schedule 3.28, has the absolute right to sell, assign, transfer, and deliver the same to the Buyer, free and clear of all claims, security interests, liens, pledges, charges, escrows, options, proxies, rights of first refusal, preemptive rights, mortgages, hypothecations, prior assignments, title retention agreements, indentures, security agreements, or any other limitation, encumbrance, or restriction of any kind.

(e) Except as set forth in Schedule 3.28, to the Knowledge of Seller, the Joint Ventures, and as of the Closing Date, the Converted Ventures, do not control, directly or indirectly, or have any direct or indirect equity participation in any corporation, limited liability company, partnership, trust, or other business association.

3.29. Quality and Condition of Assets. The Assets and the Excluded Assets constitute all assets that are held or used by Seller or its Wholly Owned Subsidiaries for the conduct of the Hospital Businesses in the manner conducted as of the date of this Agreement. Except as set forth in Schedule 3.29, to the Knowledge of Seller, all buildings, structures, facilities, and Material Tangible Assets included in the Assets are free from material defects and are usable in the regular and ordinary course of business, and conform in all material respects to all applicable Legal Requirements relating to their use and operation by Seller or its Wholly Owned Subsidiaries.

3.30. Experimental Procedures. Seller (or any Wholly Owned Subsidiary thereof) has not performed or permitted the performance of any experimental or research procedures or studies involving patients of the Hospital Businesses not authorized and conducted in accordance with the procedures of the Institutional Review Board of the Hospital.

3.31. Full Disclosures. This Agreement, the Schedules hereto, and all Closing Documents furnished and to be furnished to Buyer and their representatives by Seller pursuant hereto, when taken in their entirety, do not and will not include any untrue statement of a material fact. Copies of all documents referred to in any Schedule hereto in the possession of Seller have been delivered or made available to Buyer and its representatives and constitute true, correct, and complete copies thereof and include all amendments, exhibits, schedules, appendices, supplements, or modifications thereto or waivers thereunder.

4. REPRESENTATIONS OF BUYER

Buyer makes the following representations to Seller on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization.

(a) Buyer is a corporation duly organized and validly existing and in good standing under the laws of Connecticut. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease

and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. Buyer has made available to Seller a true and complete copy of its organizational documents.

(b) PMH is a corporation duly organized and validly existing and in good standing under the laws of Delaware. PMH has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing.

4.02. Power and Authority; Due Authorization.

(a) Buyer has full power and authority to (i) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (ii) perform its obligations under this Agreement and such Closing Documents and (iii) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary corporate action.

(b) PMH has full power and authority to (i) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (ii) perform its obligations under this Agreement and such Closing Documents and (iii) consummate the transactions contemplated by this Agreement. The execution and delivery by PMH of this Agreement and the Closing Documents to which it is or becomes a party, the performance by PMH of its obligations under this Agreement and such Closing Documents, and the consummation by PMH of the transactions contemplated by this Agreement have been duly authorized on behalf of PMH by all necessary corporate action.

4.03. Consents; Absence of Conflicts, Etc.

(a) The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(i) are within its corporate powers, are not in contravention of its certificate of incorporation, shareholders agreement, and bylaws and have been approved by all required corporate action;

(ii) do not violate any Legal Requirement to which it is subject;

(iii) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound;

(iv) will not violate any statute, law, rule, or regulation of any governmental authority to which it may be subject; and

(v) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which it may be subject.

(b) The execution, delivery and performance by PMH of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(i) are within its corporate powers, are not in contravention of its certificate of incorporation, shareholders agreement, and bylaws and have been approved by all required corporate action;

(ii) do not violate any Legal Requirement to which it is subject;

(iii) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound;

(iv) will not violate any statute, law, rule, or regulation of any governmental authority to which it may be subject; and

(v) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which it may be subject.

4.04. Due Execution; Binding Agreement. This Agreement has been duly and validly executed and delivered by Buyer. Each Closing Document to which Buyer will be a party will be duly and validly executed and delivered by Buyer at the Closing. This Agreement constitutes, and each of the Closing Documents to which Buyer will be a party will constitute (upon execution and delivery thereof by Buyer at the Closing), the valid and legally binding obligations of Buyer, enforceable against it in accordance with the terms hereof and thereof.

4.05. Proceedings. There are no claims, Proceedings, or investigations pending or, to Buyer's knowledge, threatened that: (a) adversely affect or seek to prohibit, restrain, or enjoin the execution and delivery of this Agreement, (b) adversely affect or question the validity or enforceability of this Agreement, (c) question the power or authority of Buyer to carry out the transactions contemplated by, or to perform its obligations under, this Agreement, or (d) would result in any change that would adversely affect in any material respect the ability of Buyer to perform any of its obligations hereunder.

4.06. Availability of Funds. Buyer will have and will apply at the time of Closing sufficient cash or other immediately available funds necessary to enable Buyer to consummate the transactions contemplated hereby in accordance with the terms hereof.

5. PRE-CLOSING COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by Buyer, Seller will, and will require its Affiliates and Wholly Owned Subsidiaries to:

(a) carry on its business pertaining to the Hospital Businesses in substantially the same manner as presently conducted and not make any material change in personnel, operations, finance, accounting policies, or real or personal property pertaining to the Hospital Businesses;

(b) maintain the Hospital Businesses and all parts thereof in good operating condition, ordinary wear and tear excepted;

(c) perform all of its material obligations under agreements relating to or affecting the Hospital Businesses or the Assets;

(d) comply in all material respects with all applicable laws and other Legal Requirements;

(e) keep in full force and effect present insurance policies or other comparable insurance pertaining to the Hospital Businesses; and

(f) use its commercially reasonable efforts to maintain and preserve its business organizations intact, retain its present employees of the Hospital Business, and maintain its relationships with physicians, suppliers, customers, and others having business relations with the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to by Buyer in writing, Seller will not, and will not permit any Affiliate or Wholly Owned Subsidiary to:

(a) amend or terminate any of the Assumed Contracts, enter into any Contract or commitment, or incur or agree to incur any liability, except as provided herein or in the ordinary course of business and in no event greater than Seventy-Five Thousand Dollars ($75,000) per item;

(b) enter into any Contract or commitment with physicians or other referral sources;

(c) increase compensation payable or to become payable or make any bonus payment to or otherwise enter into one or more bonus agreements with any employee of the Hospital Businesses, except increases in compensation or bonus payments or agreements that are otherwise made in the ordinary course of business consistent with past practices and in accordance with existing personnel policies;

(d) create, assume, or permit to exist any new debt, mortgage, pledge, or other lien or encumbrance upon any of the Assets in an amount in excess of Seventy-Five Thousand Dollars ($75,000) whether now owned or after acquired;

(e) acquire (whether by purchase or lease) or sell, assign, lease, or otherwise transfer or dispose of any property (including Real Property), plant, or equipment having a net book value in excess of Seventy-Five Thousand Dollars ($75,000), except in the ordinary course of business;

(f) purchase capital assets other than in accordance with the approved capital budget of Seller previously provided to Buyer;

(g) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided;

(h) hire or terminate the employment of any employee of the Hospital Businesses at the level of manager or higher (including, without limitation, any officer of the Hospital Businesses);

(i) sell or factor any Accounts Receivable;

(j) cancel, forgive, release, discharge or waive any Person's obligation to pay or to perform obligations in respect of any Assets, or agree to do any of the foregoing, except in the ordinary course of the business of the Hospital Businesses consistent with past practices;

(k) change any accounting method, policy or practice or reduce any reserves in the Financial Statements, except (i) reductions in reserves pertaining to Government Payment Programs or third party payors made in the ordinary course of business consistent with past practices and (ii) changes required by changes in GAAP or applicable Legal Requirements;

(l) terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for amendments required to comply with this Agreement or applicable Legal Requirements;

(m) amend or agree to amend the governing documents of any Joint Venture, except (x) immaterial amendments or amendments required to comply with applicable Legal Requirements or to assign and transfer to Buyer the Seller's ownership interest in, or for Buyer to become a partner or member of, the Joint Venture, or (y) as contemplated by Section 5.19 hereof; or

(n) take any action outside the ordinary course of business of the Hospital Businesses or their related ancillary services.

5.03. Employee Matters.

(a) As of the Closing Date, Seller shall terminate all of its employees at the Hospital Businesses, and Buyer shall offer employment to all active employees in good standing as of the Closing Date who satisfy customary pre-employment screening procedures, in positions similar to those then being provided by Seller. Nothing herein shall be deemed to affect or limit in any way normal management prerogatives of Buyer with respect to employees or to create or grant to any such employees third party beneficiary rights or claims of any kind or nature. In respect of the employees employed by Buyer as of the Closing Date, and except as limited by the terms of applicable collective bargaining agreements, Buyer shall provide such employees with regionally competitive wages and employee benefits comparable to the wages and benefits generally offered to employees of other hospitals owned and operated by Buyers as of the Closing Date and shall honor prior length of service for purposes of determining eligibility and vesting in its benefit plans; *provided*, *however*, that no such prior service credit need be given in respect of any new plan commenced or participated in by Buyer and generally applicable to other hospitals owned and operated by Buyer in which no prior service credit is given to or recognized for other plan beneficiaries. In extending such benefits, Buyer shall give such employees credit for the satisfaction of pre-existing condition limitations in its welfare benefit plans to the same extent that such employees have satisfied such limitations under the current welfare benefit plans of Seller. Notwithstanding anything to the contrary contained in this Section 5.03, Buyer shall not have any obligation to offer employment to, or continue to employ, any employee (x) at the Hospital Businesses who has been excluded from participation in federal health care programs, or (y) whose name is not set forth on the Employee Lists.

(b) Not later than fifteen (15) days prior to the Closing, Seller shall deliver to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Wholly Owned Subsidiaries (indicating in the list whether each employee is classified as exempt or nonexempt by Seller or such Wholly Owned Subsidiary), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Wholly Owned Subsidiaries (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor) (collectively, the "**Employee Lists**").

(c) Buyer and Seller intend that the sale of Assets contemplated by this Agreement (the "**Asset Sale**") shall constitute a bona fide arm's-length sale of assets to an unrelated buyer under Section 4204 of ERISA, 29 U.S.C. §1384, and that such Asset Sale shall not result in a complete or partial withdrawal from the Multiemployer Plans by Seller. Buyer and Seller intend that the Asset Sale will not cause the imposition of withdrawal liability on Seller, and agree to take any and all actions

required or desirable so that no withdrawal liability is imposed as a result of the Asset Sale. It is the parties understanding that no withdrawal liability will occur with respect to the New England Health Care Employees Pension Fund as a result of the Asset Sale. If withdrawal liability will occur with respect to the New England Health Care Employees Pension Fund, then the remaining provisions of this Section 5.03 shall apply to that Multiemployer Plan. For the avoidance of doubt, the remaining provisions of this Section 5.03 shall apply (i) to the New England Health Care Employees Pension Fund, if withdrawal liability will occur with respect to such Multiemployer Plan, and (ii) in any event, to the Connecticut Health Care Associates Pension Fund.

(d) Buyer shall be obligated to contribute and shall contribute to the Multiemployer Plan, for the plan year in which the Closing Date occurs and the subsequent five (5) plan years, for at least substantially the same number of contribution base units (as defined in Section 4001(a)(11) of ERISA, 29 U.S.C. §1301) for which Seller had an obligation to contribute to the Multiemployer Plan before the Closing Date.

(e) The parties hereto shall cooperate and jointly apply to the Multiemployer Plan before the first day of the first plan year beginning immediately after the Closing to obtain an exemption or variance from the sale contract language of Section 4204(a)(1)(C) of ERISA, to the extent an exemption or variance is available with respect to same.

(f) Unless an exemption or variance from the requirements of Section 4204(a)(1)(B) of ERISA is timely obtained, Buyer shall provide to the Multiemployer Plan, for the first plan year beginning after the Closing Date, and for each of the four (4) plan years thereafter (for a total of five (5) plan years), a corporate surety bond or escrow account (or letter of credit or other security that is acceptable to the Multiemployer Plan) that complies with Section 4204(a)(1)(B) of ERISA (the "**Bond/Escrow**"), in an amount equal to the greater of:

(i) the average annual contribution required to be made to the Multiemployer Plan by Seller under the Multiemployer Plan for the three (3) plan years preceding the plan year in which the Closing Date occurs; or

(ii) the annual contribution required to be made to the Multiemployer Plan by Seller under the Multiemployer Plan for the plan year immediately preceding the plan year in which the Closing Date occurs.

(g) Any Bond/Escrow shall provide that it shall:

(i) be paid to the Multiemployer Plan if Buyer fully or partially withdraws for any reason (or ceases to have an obligation to contribute) from the Multiemployer Plan at any time during the first five (5) plan years commencing with the first plan year beginning after the Closing Date, or fails to make any

required contribution to the Multiemployer Plan when due, at any time during the first five (5) plan years beginning after the Closing Date; and

(ii) be released or returned to Buyer under all other circumstances.

(h) The cost of the Bond/Escrow shall be borne by Buyer. Seller, upon request, will reasonably cooperate with Buyer in obtaining an exemption or variance for Buyer from the Bond/Escrow requirements of Section 4204(a)(1)(B) of ERISA, to the extent a regulatory exemption is available. Buyer, upon request, will reasonably cooperate with Seller in obtaining an exemption or variance for Seller from the sale/contract requirements of Section 4204(a)(1)(C) of ERISA, to the extent a regulatory exemption is available.

(i) To the extent required under Section 4204(a)(1)(C) of ERISA, if Buyer withdraws from the Multiemployer Plan in a complete withdrawal or a partial withdrawal during the period of five (5) plan years commencing with the first plan year beginning after the Closing Date, Seller will be secondarily liable to the Multiemployer Plan for any withdrawal liability amount that Seller would have had to the Multiemployer Plan as of the Closing Date but for the application of Section 4204 of ERISA, if the liability of the Buyer with respect to the Multiemployer Plan is not paid; *provided*, *however*, that the preceding language will be void and of no effect if the parties obtain an exemption or variance from the requirements of Section 4204(a)(1)(C) of ERISA.

(j) If all or substantially all of Seller's assets are distributed, or if Seller is liquidated before the end of the five (5) plan year period, Seller, except as otherwise agreed to by the Multiemployer Plan, shall provide a bond or amount in escrow equal to the value of the withdrawal liability at the time of Closing.

(k) If any party hereto fails to abide by and/or satisfy any obligation under this Section 5.03, or if complete or partial withdrawal liability is otherwise assessed by the Multiemployer Plan for any reason before the end of the five (5) plan year period, then to the extent that there is any withdrawal liability imposed by the Multiemployer Plan, Seller shall hold harmless and indemnify Buyer for the present value of the withdrawal liability that would have been imposed on Seller but for Section 4204 of ERISA (the "**Seller's Withdrawal Liability**"). Buyer shall similarly hold harmless and indemnify Seller for any withdrawal liability amount in excess of Seller's Withdrawal Liability.

(l) Buyer and Seller agree to cooperate with the Multiemployer Plan to accomplish this Asset Sale without triggering withdrawal liability.

(m) Buyer covenants and agrees to require any subsequent purchaser of the Hospital Business and/or all of the assets of the Hospital Business to apply the procedures of Section 4204(a) of ERISA to the Multiemployer Plan. This Section 5.03(m) shall remain in effect for a period of five (5) years commencing with the first plan year beginning after the Closing Date.

5.04. Access to and Provision of Additional Information.

(a) Seller shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Buyer full and complete access to and the right to inspect the plants, properties, books, and records of the Hospital Businesses, and will furnish Buyer with such additional financial and operating data and other information as to the business and properties of Seller pertaining to the Hospital Businesses as Buyer may from time to time reasonably request without regard to where such information may be located. Buyer's right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Hospital Businesses and the delivery of patient care. Buyer agrees that no inspections shall take place and no employees or other personnel of the Hospital Businesses shall be contacted by Buyer without Buyer's first providing reasonable notice to Seller and coordinating such inspection or contact with Seller.

(b) Within two (2) business days after they are created (but in any event no later than fifteen (15) days following the end of each calendar month prior to Closing), Seller shall deliver or cause to be delivered to Buyer true and complete copies of the management prepared unaudited balance sheets and the related unaudited statements of income of, or relating to, Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses for each month then ended, which presentation shall be true, correct, and complete in all material respects, shall have been prepared from and in accordance with the books and records of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses, and shall fairly present the financial position and results of operations of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such financial statements need not include required footnote disclosures. To the extent permitted by law, Seller shall notify Buyer in writing and shall keep Buyer informed of any unexpected emergency or other materially adverse unanticipated change in the business of any of the Hospital Businesses and of any governmental complaints, investigations, or adjudicatory proceedings (or governmental communications indicating that the same may be contemplated) or of any other such matter.

(c) Until the Closing Date, to the extent permitted by law, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, grievances, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any individually identifiable health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with HIPAA and with any other Legal Requirements that govern or pertain to the

confidentiality, privacy, security of, and electronic transactions involving, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this Section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Governmental Approvals.

(a) Seller's Obligations.

(i) Seller shall (a) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Seller to perform its obligations under this Agreement (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein); and (b) assist and cooperate with Buyer and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Buyer deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein).

(ii) Seller shall, if and to the extent required by Legal Requirements, file all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Seller agrees to furnish to Buyer such information concerning Seller as Buyer needs to perform its obligations under Section 5.05(b)(ii) of this Agreement.

(b) Buyer's Obligations.

(i) Buyer shall (a) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Buyer to perform its obligations under this Agreement (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of

the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein), and (b) assist and cooperate with Seller and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Seller deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein). Buyer shall pay all of the costs of any fees due in respect of filings made to the Attorney General and Commissioner of Public Health of the State of Connecticut, including, without limitation, fees required to be paid by Buyer pursuant to CT Gen Stat § 19a-486c(c) and CT Gen Stat § 19a-486d(a) shall remain the obligation of Buyer.

(ii) Buyer shall, if and to the extent required by Legal Requirements, file or cause to be filed all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Buyer agrees to furnish to Seller such information concerning Buyer as Seller needs to perform its obligations under Section 5.05(a)(ii) of this Agreement. Buyer shall pay the costs of any fees due in respect of filings required by the HSR Act.

5.06. Connecticut Transfer Act. Certain components of the Real Property (including the Hospital) may constitute, in whole or in part, "Establishments" as the term is defined in the Transfer Act (collectively, the "**Establishment Real Properties**"). Accordingly, Seller and Buyer shall prepare an appropriate Transfer Act Form and accompanying Environmental Condition Assessment ("**ECAF**") for each Establishment Real Property to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Seller shall execute as transferor and Buyer shall execute as transferee and Certifying Party (as all such terms are defined in the Transfer Act). Within ten (10) days after the Closing Date, Buyer shall (i) file the fully executed Transfer Act Form and ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEEP**"); (ii) pay the initial filing fee and any and all subsequent Transfer Act fees (which shall be reimbursed by Seller); and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). In order to evaluate the potential scope and cost of Transfer Act obligations that may be required, prior to the Closing, Buyer shall have the right to perform limited Phase II assessments with respect to the Real Property. Buyer or its designee shall conduct and complete, at Buyer's sole expense, any actions required (as determined by Buyer in its reasonable discretion) as a result of the filing of the Transfer Act Form and the ECAF, to comply with the Transfer Act,

and, if appropriate, to obtain written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" that the Hospital Businesses have been remediated in full compliance with the Connecticut Remediation Standard Regulations (collectively "**Transfer Act Activities**"). Buyer shall complete all Transfer Act Activities as soon as practicable, but in any event within any deadline defined by or pursuant to the Transfer Act (as the same may be extended). Seller shall pay Buyer for all costs and expenses that Buyer incurs in connection with Transfer Act Activities in an amount not to exceed One Hundred Thousand Dollars ($100,000) (the "**Estimated Remediation Costs**"). Seller and Buyer agree to execute and deliver all documents reasonably requested by the other to comply with the Transfer Act. All undefined terms in this Section 5.06 shall have the meanings set forth in the Transfer Act.

5.07. No-Shop Clause. Seller agrees that, from and after the date of the execution and delivery of this Agreement by Seller until the termination of this Agreement, neither Seller, nor any Affiliate of Seller will, without the prior written consent of Buyer: (i) offer for sale the Assets (or substantially all of the Assets) or any ownership interest in any entity owning any of the Assets, (ii) solicit offers to buy all or substantially all of the Assets or any ownership interest in any entity owning any of the Assets, (iii) hold discussions with any party (other than Buyer) looking toward such an offer or solicitation or looking toward a merger, consolidation, joint venture, or similar transaction involving any entity owning any of the Assets, or (iv) enter into any agreement with any party (other than Buyer) with respect to the sale or other disposition of the Assets (or substantially all of the Assets) or any ownership interests in any entity owning any of the Assets or with respect to any merger, consolidation, joint venture, or similar transaction involving any entity owning any of the Assets. Seller will promptly communicate to Buyer the substance of any inquiry or proposal concerning any such transaction.

5.08. Casualty. If, on or before the Closing Date, any of the Real Property used by the Hospital Businesses is destroyed or damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Real Property, in the aggregate, is rendered unsuitable for their primary intended use for at least six (6) months, Buyer may elect, by giving written notice to Seller within ten (10) business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this Agreement in accordance with Section 9.04(a)(v), (ii) consummate the transaction in spite of such destruction or damage, but reduce the Purchase Price by the fair market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds (or the right to receive the insurance proceeds) payable on account of such destruction or damage, plus any deductibles or copayments required under the applicable insurance policy in respect of such claim. In the absence of an agreement among the parties regarding the amount of any Purchase Price reduction for purposes of clause (ii) above (if applicable), an MAI appraiser mutually selected by the parties and paid equally by Seller, on the one hand, and Buyer, on the other hand, will determine any reduction in Purchase Price pursuant to such clause (ii).

5.09. Consents to Assignment.

(a) Seller shall (or shall cause its Wholly Owned Subsidiaries to) promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing, provided that Seller and its Wholly Owned Subsidiaries shall not be required to make any payments or economic concessions to landlords or other counterparties to obtain such consents.

(b) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a contract that supersedes or replaces an existing Contract between Seller (or its Wholly Owned Subsidiary) and a third party. Such new contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller (or its Wholly Owned Subsidiary) that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller (or its Wholly Owned Subsidiary) that are Excluded Liabilities. If Buyer enters into a replacement contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 10), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement contract did not exist or such assumption of Excluded Liabilities was not required.

5.10. Insurance Ratings. Seller will take all action reasonably requested by Buyer to enable Buyer to succeed to the workers' compensation and unemployment insurance ratings, and other ratings for insurance or other purposes established by Seller or its Affiliates for the Hospital Businesses. Buyer shall not be obligated to succeed to any such ratings, except as Buyer may elect to do so.

5.11. Efforts to Close.

(a) Seller shall use its commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Seller shall notify Buyer as soon as practicable of any event or matter that comes to its attention that may reasonably be expected to prevent or materially delay the conditions to the obligations of Seller being met.

(b) Buyer shall use its commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Buyer shall notify Seller as soon as practicable of any event or matter that comes to the attention of Buyer that may reasonably be expected to prevent or materially delay the conditions to Buyer's obligations being met.

5.12. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets, other than the Permitted Encumbrances, to be released and discharged at or before Closing.

5.13. [Intentionally Omitted.]

5.14. Medical Staff Disclosure. Seller shall deliver to Buyer a confidential written disclosure containing a brief description of all adverse actions taken against medical staff members or applicants in the past three (3) years that, to the Knowledge of Seller, could result in claims or actions against Seller, its Wholly Owned Subsidiaries or the Hospital Businesses and that are not disclosed in the minutes of the meetings of the Medical Executive Committee of the medical staff of the Hospital Businesses, which have been provided to Buyer.

5.15. Satisfaction of Bond Obligations. At its sole cost and expense, Seller shall do all things necessary, desirable, and appropriate to cause the complete and valid payment or, if necessary, defeasance of its obligations under that certain Loan Agreement and Security Agreement dated as of December 1, 2010 by and between Seller, the Hospital, RBS Citizens, National Association, and the State of Connecticut Health and Educational Facilities Authority (the "**Loan Agreement**"), which secures the State of Connecticut Health and Educational Facilities Authority Revenue Bonds, Waterbury Hospital Issue, Series D, such that all liens and mortgages secured by the Loan Agreement shall be released at the time of the Closing.

5.16. New and Existing Collective Bargaining Agreement.

(a) Seller is currently party to three collective bargaining agreements:

(i) The "Nurses CBA" is between the Seller and Connecticut Health Care Associates and covers registered nurses and licensed practical nurses with effective dates from October 1, 2013 through September 30, 2017. Neither the Buyer nor the Seller expect that the Nurses CBA shall be renegotiated prior to the Closing. The Seller shall not enter into any modification of the Nurses CBA prior to the Closing without the express written consent of the Buyer. The Buyer shall accept the terms of the Nurses CBA, as adjusted with regard to pension benefits and hire bargaining unit employees as set forth in the Letter of Agreement on Successorship contained in the Nurses CBA. The Buyer shall provide the Union a written notice of such acceptance at least thirty (30) days prior to the Closing in accordance with said Letter of Agreement on Successorship.

(ii) The "Technical Unit CBA" is between the Seller and Connecticut Health Care Associates and covers technical employees with effective dates from December 9, 2015 through September 30, 2018. Neither the Buyer nor the Seller expect that the Technical Unit CBA shall be renegotiated prior to the Closing. The Seller shall not enter into any modification of the Technical Unit CBA prior to the Closing without the express written consent of the Buyer. The Buyer shall accept the terms of the Technical Unit CBA and hire bargaining unit employees as set forth in the Letter of Agreement on Successorship contained in the Technical Unit CBA. The Buyer shall provide the Union a written notice of such

acceptance at least thirty (30) days prior to the Closing in accordance with said Letter of Agreement on Successorship.

(iii) The "Service & Maintenance CBA" is between the Seller and New England Health Care Employees Union, District 1199 with effective dates from March 1, 2016 through February 28, 2017. Neither the Buyer nor the Seller expect that the Service & Maintenance CBA shall be renegotiated prior to the Closing. The Seller shall not enter into any modification of the Service & Maintenance CBA prior to the Closing without the express written consent of the Buyer. The Buyer shall accept the terms of the Service & Maintenance CBA and hire bargaining unit employees as set forth in the Letter of Agreement on Successorship contained in the Service & Maintenance CBA. The Buyer shall provide the Union a written notice of such acceptance at least thirty (30) days prior to the Closing in accordance with said Letter of Agreement on Successorship.

(b) If, prior to the Closing, any bargaining obligations arise to the Seller to a bargaining unit not covered by any of the three existing collective bargaining agreements, Seller shall immediately notify Buyer. The Seller shall keep Buyer apprised of, and consult with Buyer regarding, the status of negotiations for a collective bargaining agreement for any such additional bargaining unit. Seller shall not, without the Buyer's written consent, enter into any collective bargaining agreement covering any such unit that contains terms that the Buyer reasonably believes will impact Buyer's ability to operate the Hospital after the Closing. Buyer shall not interfere with Seller's bargaining obligations under the National Labor Relations Act.

5.17. Title Commitment. Buyer shall obtain a current title commitment (the "**Title Commitment**") issued by Commonwealth Land Title Insurance Company (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein. The Title Commitment shall set forth the state of title to the Owned Real Property, together with all exceptions or conditions to such title, including, without limitation, all easements, restrictions, rights-of-way, covenants, reservations, and all other encumbrances affecting the Owned Real Property that would appear in an owner's title policy, if issued. The Title Commitment shall contain the express commitment of the Title Company to issue an Owner's Title Policy (the "**Title Policy**") to Buyer in an amount equal to the amount being allocated by the parties to the Owned Real Property insuring good and marketable title to the Owned Real Property subject only to the Permitted Encumbrances with the standard printed exceptions endorsed or deleted as agreed by Buyer.

5.18. Surveys. Seller shall deliver copies of all existing surveys of the Real Property, in its possession, to Buyer. Buyer may obtain, at its sole cost and expense, current as-built surveys of the Real Property (the "**Surveys**"). The Surveys shall meet the requirements of an ALTA/ASCM survey and otherwise be in form and detail satisfactory to Buyer. Unless otherwise agreed by Buyer, the Surveys shall (i) be currently dated; (ii) show the location on the Real Property of all improvements, fences, evidences of abandoned fences, lakes, ponds, creeks, streams, rivers, easements, roads, and rights-of-way; (iii) identify all easements and rights-of-way by reference to the recording information applicable to the documents creating such

easements or rights-of-way; (iv) show any encroachments onto the Real Property from any adjacent property, any encroachments from the Real Property onto adjacent property, and any encroachments into any easement or restricted area within the Real Property; (v) locate all existing improvements (such as buildings, power lines, fences, and the like); (vi) locate all dedicated public streets or other roadways providing access to the Real Property, including all curb cuts and all alleys; (vii) locate all set-back lines and similar restrictions covering the Real Property or any part thereof and any violations of such restrictions; and (viii) show thereon a legal description of the boundaries of the Real Property by metes and bounds or other appropriate legal description. Each Survey shall contain the surveyor's certification to Buyer, Seller, and the Title Company that (i) the Survey was made on the ground; (ii) there are no visible or recorded easements, discrepancies, conflicts, encroachments, or overlapping of improvements except as shown on the Survey; (iii) the Survey correctly shows all visible or recorded easements or rights of way across the Real Property or any other easements or rights of way of which the surveyor has been advised, including, without limitation, those matters affecting title reflected in the Title Commitment; (iv) the Survey correctly shows the location of all buildings, structures, and other improvements situated on the Real Property; (v) the Survey conforms to all applicable minimum guidelines for surveys of comparable property as set forth in applicable laws, regulations, or professional standards; (vi) all streets abutting the Real Property and all means of ingress to and egress from the Real Property have been completed, dedicated, and accepted for public maintenance by the relevant municipal body; (vii) except as shown thereon, the Real Property is not located within the 100 year flood plain or other flood hazard area; (viii) the Survey is a true, correct, and accurate representation of the Real Property; and (ix) such other matters as may be required by the Title Company to allow it to issue the Title Policy.

5.19. Conversion of Non-Profit JVs. If requested by Buyer, each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its respective representatives and counsel to cooperate with, the other party to take all necessary, proper or advisable actions to consummate the conversion of each of the Non-Profit JVs into for-profit entities. Upon the consummation of each such conversion, the new for-profit entity shall be referred to herein as a "**Converted Venture**."

6. ADDITIONAL COVENANTS

6.01. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five (5) years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies maintained by such party. In addition, to facilitate the foregoing purposes, each party shall also make such books, records,

documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense, any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to cooperate with, the other party after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this Section shall not unreasonably interfere with the conduct of business of the other party and nothing in this Section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) Buyer agrees to abide by all applicable laws relating to the confidential information it acquires. Buyer agrees to maintain the patient records delivered to Buyer at the Closing at the Hospital Businesses after Closing in accordance with applicable Legal Requirements (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. §1395(v)(l)(i)), the privacy and security requirements of HIPAA, including, but not limited to, the Administrative Simplification subtitle of HIPAA, and applicable state requirements with respect to medical privacy and security and requirements of relevant insurance carriers, all in a manner consistent with the maintenance of patient records generated by the Hospital Businesses after the Closing.

6.02. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed 120 days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller and its Wholly Owned Subsidiaries relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney (on behalf of itself and its Wholly Owned Subsidiaries, as applicable) substantially in the form of Exhibit B hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall indemnify and hold harmless Seller and its Wholly Owned Subsidiaries, and their officers, trustees and employees for all claims, liabilities and costs arising from or relating to use of such licenses and registration after the Closing Date.

6.03. Noncompetition. Seller hereby covenants that at all times from the Closing Date until the fifth (5th) anniversary of the Closing Date, Seller and its Affiliates shall not, directly or indirectly, except as a member, consultant, or contractor to or of Buyer (or any Affiliate of Buyer), own, lease, manage, operate, control, or participate in any manner with the ownership, leasing, management, operation, or control of any business that offers services in competition with the Hospital Businesses, including but not limited to any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a thirty (30) mile radius of the Hospital (the "**Restricted Area**"), without Buyer's prior written consent (which Buyer may withhold in its sole and absolute discretion); *provided*, *however*, that (i) Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates through the Hospital: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services provided by Buyer, and (ii) Seller and its Affiliates will not be precluded from participating in activities that are otherwise described in Schedule 6.03 of this Agreement. In the event of a breach of this Section 6.03, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Seller and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section 6.03 form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section 6.03. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

6.04. Allocation of Purchase Price; Cooperation on Tax Matters.

(a) Within a reasonable time after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospital Businesses and the Assets. Such allocation will be in accordance with Section 1060 of the Code. Buyer's proposed allocation will become final and binding on the parties 45 days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within 60 days after Seller gave its objection to Buyer. If a final resolution is not reached within 60 days after Seller

has submitted its objection in writing, each of Buyer and Seller shall make their own independent allocation of the total consideration among the Hospital Businesses and the Assets. If Seller and Buyer reach agreement upon the allocation (or Seller does not object to Buyer's proposed allocation), Seller and Buyer will be bound by the agreed allocation and (for federal and state Tax purposes) account for and report the transactions contemplated by this Agreement in accordance with such allocation, and will not voluntarily take any position (whether in Tax Returns, Tax audits or other Proceedings) inconsistent with such allocation. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the IRS in accordance with such allocation.

(b) Following the Closing, the parties shall cooperate fully with each other and shall make available to the other, as reasonably requested and at the expense of the requesting party, and to any taxing authority (to the extent required by Legal Requirements), all information, records, or documents in their possession relating to the Assets, the Hospital Businesses, and the Assumed Liabilities as is reasonably necessary for the preparation and filing of any Tax Return, claim for refund of Taxes, or other filings relating to Taxes, or in connection with any audit or other proceeding instituted by any taxing authority. In the case of any audit, examination, or other proceeding with respect to Taxes for which Seller is or may be liable pursuant to this Agreement, Buyer shall promptly inform Seller, and Buyer shall execute or cause to be executed powers of attorney or other documents necessary to enable Seller to take all actions reasonably deemed necessary by Seller with respect to such audit, examination, or proceeding to the extent such audit, examination, or proceeding may affect the amount of Taxes for which Seller is liable pursuant to this Agreement. Seller shall have the right to control any such audit, examination, or proceeding, and, if there is a reasonable basis therefor, to initiate any claim for refund, file any amended return, or take any other action that it deems appropriate with respect to such Taxes.

6.05. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this

Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

6.06. Seller's Cost Reports. Seller, at its expense, shall prepare and timely file all terminating and other cost reports required or permitted by law to be filed under the Government Payment Programs or other third party payor programs and the State Health Agency for periods ending on or prior to the Closing Date, or as a result of the consummation of the transactions described herein (the "**Cost Reports**"). Buyer shall provide Seller with access to all records and data necessary for completion of Cost Reports. Buyer shall forward to Seller any and all correspondence relating to Cost Reports within five (5) business days after receipt by Buyer. Buyer shall remit any receipts of funds relating to Cost Reports within ten (10) business days after receipt by Buyer and shall forward to Seller any demand for payments within five (5) business days after receipt by Buyer. Seller shall retain all rights to the Cost Reports including any amounts receivable or payable in respect of such reports or reserves relating to such reports. Such rights shall include the right to appeal any determinations by Government Payment Programs relating to Cost Reports. Seller shall retain the originals of Cost Reports, correspondence, work papers and other documents relating to Cost Reports; *provided*, *however*, that Seller shall make certain that the Hospital Businesses retain copies of such Cost Reports, correspondence, work papers and other documents in order that they are available to Buyer following the Closing Date.

6.07. Continuation of Hospital and Post-Care Continuum. For a period of at least five (5) years after Closing, Buyer (i) will continue to provide at the Hospital Businesses essential clinical and other services described on Exhibit C, and (ii) will not merge, dissolve, consolidate, sell or otherwise dispose of the Hospital without the consent of Seller or its designee (other than to an Affiliate of Buyer or PMH); *provided*, *however*, that this clause (ii) shall not prohibit Buyer from entering into or engaging in (x) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or that relates to a broader group of facilities or assets than the Hospital, or (y) any corporate-level transactions involving PMH's assets, stock or securities, including mergers, recapitalizations or reorganizations.

6.08. Sale of Hospital Within Three Years. In the event of a sale of all of the Hospital Businesses for cash, whether by merger, sale, or other transaction, at any time prior to the third (3rd) anniversary of the Closing, for a purchase price in excess of (a) the Purchase Price paid by Buyer for the Assets, *plus* (b) the amount of any expenditures made by Buyer or its Affiliates with respect to the Hospital Businesses and their affiliated businesses in the Greater Waterbury region in such period, *plus* (c) any losses generated by the Hospital Businesses and its affiliated businesses in such period (such amount, the "**Net Hospital Value**"), then Buyer agrees to convey to Seller or its designee immediately upon closing of such transaction by wire transfer of immediately available funds in an amount equal to twenty percent (20%) of the difference between (i) the Net Hospital Value and (ii) the cash purchase price paid to Buyer in connection with such subsequent sale transaction. Notwithstanding anything to the contrary this Section shall not apply to (x) any sale required by a Governmental Authority, (y) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or relates to a broader group of facilities or assets than the Hospital Businesses, or (z) any corporate-level transactions involving PMH's stock or securities, including mergers, recapitalizations or reorganizations.

6.09. Charity Care and Community Obligations. Seller has historically provided significant levels of care for indigent and low-income patients. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will ensure that the Hospital maintains and adheres to Seller's current policies on charity care, attached as Schedule 6.09 for at least five (5) years from Closing. During all times that Buyer owns and operates the Hospital, Buyer will operate the Hospital's charity care program in accordance with Legal Requirements, and will continue to provide medically necessary services to the surrounding communities served by Seller. For a period of at least five (5) years after the Closing, Buyer shall (i) participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, (ii) accept all emergency patients without regard to ability to pay, (iii) maintain an open medical staff; (iv) provide public health programs of educational benefit to the community, and (v) generally promote public health, wellness, and welfare to the community by operating the Hospital with quality standards consistent with other hospitals owned by PMH, subject, in each case, in all respects to changes in governmental law, policy or regulation.

6.10. Capital Commitment. After the Closing, Buyer agrees to spend or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) not less than the Capital Amount in the seven (7) years following the Closing Date on capital projects, including routine and non-routine capital expenditures, at, or for the benefit of, the Hospital Businesses and/or the acquisition, development and improvement of hospital, ambulatory or other health care services in the greater Waterbury, Connecticut community, and which shall include, for the avoidance of doubt, expenditures relating to the implementation of PMH's coordinated regional care model (CRCM) and Physician Recruitment Expenditures.

6.11. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements or in order to coordinate the defeasance of tax-exempt debt, Seller (and its Affiliates and Wholly Owned Subsidiaries) and Buyer (and its Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party.

(b) At all times before and after the Closing, Seller, on the one hand, and PMH and Buyer, on the other hand, will consult with the other before issuing or making any reports, statements or releases to the public with respect to this Agreement or the transactions contemplated by this Agreement and will use good faith efforts to obtain the other party's prior approval of the text of any public report, statement or release to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements,

then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

6.12. Local Board. After Closing, Buyer shall form a local community advisory board comprised of between nine (9) and twelve (12) members (the "**Local Board**"). The Local Board shall include as members thereof the following individuals who shall serve in an *ex officio* capacity: (a) Chief of Medical Staff and (b) Head of Clinical Quality. In addition, a member of the board of directors of Prospect Waterbury, Inc. shall serve as a member of the Local Board and shall be selected to serve in such capacity by the board of directors of Buyer. For three (3) years following the Closing Date, one (1) community representative, to be selected by Buyer in consultation with the Mayor of Waterbury, shall serve as a voting member of the Local Board with rights and obligations consistent with other voting members under the Local Board bylaws. The Local Board shall, among other things, (i) make recommendations and suggestions to Buyer regarding the mission, vision and value statements with respect to the Hospital and the Hospital Businesses; (ii) make recommendations and suggestions with respect to medical staff credentialing, disciplinary action of staff physicians, and compliance with accreditation requirements; (iii) provide input on policies and clinical programs; (iv) provide input in the development and review of strategic plans; (v) provide input on operating and capital budgets; (vi) provide input and support physician recruitment efforts; (vii) provide input on succession plans for executive leadership at the Hospital; (viii) promote community health initiatives, fostering community relationships and identifying service and education opportunities; and (ix) monitor the commitment to maintain and improve quality indicators.

6.13. Misdirected Payments, etc. Seller and Buyer covenants and agrees to remit, with reasonable promptness, to the other any payments received, which payments are on or in respect of accounts or notes receivable owned by (or are otherwise payable to) the other. In addition, and without limitation, in the event of a determination by any governmental or third-party payor that payments to Seller or the Hospital Businesses resulted in an overpayment or other determination that funds previously paid by any program or plan to Seller or the Hospital Businesses must be repaid, Seller shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered on or prior to the Closing Date, and the Buyer shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered after the Closing Date. In the event that, following Closing, the Buyer suffers any offsets against reimbursement under any third-party payor or reimbursement programs due to Buyer, relating to amounts owing under any such programs by Buyer or any of its Affiliates, Seller shall immediately upon written demand from the Buyer pay to the Buyer the amounts so billed or offset.

6.14. Medical Staff Matters. Buyer shall adopt current bylaws and hearing procedures and otherwise work together with the Local Board and medical staff of the Hospital to preserve the existing staff membership and the current privileges of each physician, as well as the medical staff leadership.

6.15. CHA Claims. The Parties agree that the decision whether to pursue or settle the CHA Claims and all matters relating to the conduct and pursuit of the CHA Claims after the Closing Date shall be within the sole and absolute discretion of Buyer, and Seller hereby

irrevocably waives any right to challenge or otherwise make any claim against Buyer with respect to Buyer's pursuit, settlement or conduct of the CHA Claims. Seller agrees to cooperate reasonably with Buyer in pursuing the CHA Claims after the Closing Date, at the sole expense of Buyer, and Buyer will assume all costs of pursuing or settling the CHA Claims. Seller agrees to execute any documents, agreements or powers of attorney reasonably necessary or desirable to Buyer in connection with effectuating the foregoing provisions.

6.16. Additional Payment. The Parties agree that the funds deposited in escrow pursuant to Section 8.13 of this Agreement shall be used to fund the Connecticut Health Care Associates Pension Plan in accordance with the joint escrow instructions.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

Notwithstanding anything herein to the contrary, the obligations of Seller to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Seller at the Closing:

7.01. Representations; Warranties. Each of the representations and warranties of Buyer contained in this Agreement that is qualified as to materiality was true and correct in all respects when made and shall be true and correct as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date, and each of the representations and warranties of Buyer contained in this Agreement that is not qualified as to materiality was true and correct in all material respects when made and shall be true and correct in all material respects as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Buyer on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

7.02. Governmental Matters. All material consents, authorizations, orders, and approvals of (or filings or registrations with) any Government Authority or other party required in connection with the execution, delivery, and performance of this Agreement shall have been obtained or made by Buyer when so required, except for any documents required to be filed, or consents, authorizations, orders, or approvals required to be issued, after the Closing Date.

7.03. Actions; Proceedings. No Proceeding before a court or any other Government Authority, unless resolved, shall have been instituted or threatened to restrain or prohibit the transactions herein contemplated, and no Government Authority shall have taken any other action or made any request of any party hereto as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

7.04. Insolvency. Buyer shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated a bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Buyer.

7.05. Closing Documents. All Closing Documents required to be delivered to Seller pursuant to Article 9 shall have been delivered to Seller.

8. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

Notwithstanding anything herein to the contrary, the obligations of Buyer to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Buyer at the Closing:

8.01. Representations; Warranties. Each of the representations and warranties of Seller contained in this Agreement that is qualified as to materiality was true and correct in all respects when made and shall be true and correct as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date, and each of the representations and warranties of Seller contained in this Agreement that is not qualified as to materiality was true and correct in all material respects when made and shall be true and correct in all material respects as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Seller on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

8.02. Pre-Closing Confirmations. Buyer shall have obtained documentation or other evidence satisfactory to Buyer in their sole discretion that Buyer has:

(a) Received satisfactory approval from all Government Authorities whose approval is required to complete the transactions herein contemplated (including, without limitation, satisfactory approvals, with conditions acceptable to Buyer in its sole discretion, of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein);

(b) Received confirmation from all applicable licensure agencies that, upon the Closing, either (i) all Permits required by law to operate the Hospital Businesses as currently operated will be transferred to, or issued or reissued in the name of, Buyer, or (ii) Buyer will be permitted to operate the Hospital Businesses as currently operated from and after the Closing until such time as all appropriate Permits are issued or reissued in the name of Buyer;

(c) Obtained reasonable assurances that Medicare and Medicaid certification of the Hospital Businesses, including the Hospital, for their operation by Buyer will be effective as of the Closing and that Buyer may participate in and receive reimbursement from such programs effective as of the Closing;

(d) Reasonably assured itself that all waiting periods under the HSR Act have been terminated or expired and that any additional approvals required from the Justice Department and/or the FTC relating to the transactions contemplated herein have been obtained and are in form and substance satisfactory to Buyer in its reasonable discretion;

(e) Obtained reasonable assurances that the material grants and grant programs listed on Schedule 8.02(e) shall continue after the Closing; and

(f) Obtained such other consents and approvals as may be legally or contractually required for the consummation of the transactions described herein.

8.03. Actions; Proceedings. No Proceeding before a court or any other Governmental Authority, unless resolved, shall have been instituted to restrain or prohibit the transactions herein contemplated, and no Governmental Authority shall have taken any other action or made any request of any party hereto as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

8.04. Adverse Change. Since the date hereof, no event or condition has occurred or exists that could reasonably be expected to cause a Material Adverse Effect.

8.05. Insolvency. Seller shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated a bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Seller.

8.06. Consents to Assignments. Consents (including consents to assignments), waivers, and estoppels of third parties, for those certain contracts and leases set forth on Schedule 8.06 from the counterparties to such contracts and leases, shall have been obtained, received by Buyer, and are in form and substance reasonably satisfactory to Buyer.

8.07. Vesting; Recordation. Seller shall have furnished to Buyer, in form and substance satisfactory to Buyer, assignments or other instruments of transfer and consents and waivers by others, necessary or appropriate to transfer to and effectively vest in Buyer all right, title, and interest in and to the Assets, in proper statutory form for recording if such recording is necessary or appropriate.

8.08. Title Insurance Policies and Surveys. Buyer has received the Title Policy and the Surveys.

8.09. Loan Agreement. The Loan Agreement shall have been satisfied, discharged and terminated and all Encumbrances created by or in connection with the Loan Agreement shall have been released.

8.10. Waterbury Hospital Cash Balance Retirement Plan. Seller shall have taken all steps necessary to freeze the Waterbury Hospital Cash Balance Retirement Plan (the "**Cash Balance Plan**") effective as of the Closing Date so that no benefits, other than those required pursuant to a collective bargaining agreement, will accrue for any participant in the Cash Balance Plan after the Closing Date, including providing any notice of such freeze as required under applicable laws.

8.11. Closing Documents. All Closing Documents required to be delivered to Buyer pursuant to Article 9 shall have been delivered to Buyer.

8.12. Negative Amount. The estimated Negative Amount at Closing, as calculated by Seller in accordance with Section 2.05(c), shall not exceed Five Million Dollars ($5,000,000).

8.13. Escrow. Seller shall have delivered by wire transfer the amount of Three Million Dollars ($3,000,000) to an escrow agent, mutually agreed upon by the parties, to be held and disbursed in accordance with escrow instructions that shall be agreed to by the parties in writing.

9. CLOSING; TERMINATION OF AGREEMENT

9.01. Closing.

(a) Consummation of the sale and purchase of the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at Epstein Becker & Green, P.C., 1 Gateway Center, Newark, New Jersey 07102 at 10:00 a.m. on the third (3rd) business day following satisfaction or waiver of the conditions to Closing set forth in Article 7, 8 and 9, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day of the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 9.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 9.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, PMH.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and Seller shall deliver (or cause to be delivered) to Buyer control and possession of the Assets.

9.02. Action of Seller at Closing. At the Closing, Seller shall deliver to Buyer:

(a) Special Warranty Deed, fully executed by Seller in recordable form, conveying to Buyer good and marketable fee title to the Owned Real Property, and Assignment and Assumption of Leases, fully executed by Seller in recordable form, assigning to Buyer leasehold title to the Leased Real Property, in each case subject only to current Taxes not yet due and payable as of the Closing Date and the Permitted Encumbrances;

(b) A General Assignment, Conveyance, and Bill of Sale, fully executed by Seller, conveying to Buyer good and marketable title to all tangible assets that are a part of the Assets and valid title to all intangible assets that are a part of the Assets, free and clear of all liabilities, claims, liens, security interests, and restrictions other than the Assumed Liabilities and the Permitted Encumbrances (the "**Bill of Sale**");

(c) An Assignment and Assumption Agreement, fully executed by Seller, conveying to Buyer Seller's interest in the Assumed Contracts (the "**Assignment and Assumption Agreement**");

(d) All instruments, documents, and affidavits required by the Title Company to issue the Title Policy as described in and provided by Section 5.17 hereof that are consistent with the Connecticut Standards of Title;

(e) the Transitional Services Agreement, fully executed by Seller;

(f) Copies of resolutions duly adopted by the Board of Trustees of Seller, authorizing and approving the performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and of full force as of the Closing, by the appropriate officers or other representatives of Seller;

(g) A certificate of the President or a Vice President of Seller certifying that each covenant and agreement of Seller to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of Seller is true and correct on the Closing Date, as if made on and as of the Closing;

(h) Certificates of incumbency for the officers or representatives of Seller executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(i) Certificates of existence of Seller from the state in which it is incorporated, dated the most recent practical date prior to the Closing;

(j) All Certificates of Title and other documents evidencing an ownership interest conveyed as part of the Assets, including, without limitation, all JV Interests (subject to Section 2.01(q)), and Investment interests in CAGW, WMA and MMA;

(k) An affidavit stating that Seller is not a "foreign person" as defined in Section 1445(f)(3) of the Code, as amended;

(l) All necessary state and local real estate conveyance Tax forms duly executed by Seller;

(m) Final execution copy of the Transfer Act Form III and ECAF, as more fully described in Section 5.06;

(n) Limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers, in substantially the form of Exhibit B attached hereto, fully executed by Seller; and

(o) Such other instruments and documents as Buyer reasonably deems necessary to effect the transactions contemplated hereby.

9.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) The Purchase Price due to Seller as adjusted in accordance with Section 2.05;

(b) Copies of resolutions duly adopted by the Board of Directors of PMH and Buyer authorizing and approving the performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and in full force as of the Closing, by the appropriate officers of PMH and Buyer;

(c) A certificate of the President or a Vice President of Buyer certifying that each covenant and agreement of Buyer to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of Buyer is true and correct on the Closing Date, as if made on and as of the Closing;

(d) A certificate of incumbency for the respective officers of PMH and Buyer executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(e) Certificates of existence and good standing of Buyer from the state in which Buyer is formed or incorporated, dated the most recent practical date prior to Closing;

(f) Such other instruments and documents as Seller reasonably deems necessary to effect the transactions contemplated hereby;

(g) The Transitional Services Agreement, fully executed by Buyer;

(h) Final execution copy of the Transfer Act Form III and ECAF with a $3,000 initial filing fee, as more fully described in Section 5.06; and

(i) Such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this Agreement.

9.04. Termination Prior to Closing.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller, if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the

transactions contemplated by this Agreement as set forth in Article 8; (iii) by Seller, by written notice to Buyer, if any event occurs or condition exists that causes Buyer to be unable to satisfy one or more conditions to the obligations of Seller to consummate the transactions contemplated by this Agreement as set forth in Article 7; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before December 31, 2016 (*provided, however*, that, Buyer shall have the right, exercisable upon prior written notice to Seller, to extend such date by up to an additional thirty (30) days if all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied other than the receipt of approvals from all governmental authorities whose approval is required to complete the transactions herein contemplated, but only if Buyer is diligently pursuing such remaining governmental approvals or contesting in good faith any of the terms or conditions of such approvals, including, without limitation, pursuing any changes in respect of the conditions imposed on the operation of the Hospital or the related businesses or any other modifications set forth in such approval); *provided*, *however*, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; or (v) by Buyer, pursuant to Section 5.08.

(b) If this Agreement is validly terminated pursuant to Section 9.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 9.04(a), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity, (ii) the termination fee provisions of Section 9.04(d), the expense allocation provisions of Section 11.21 and the confidentiality provisions of Section 6.11 shall remain in full force and effect and survive any termination of this Agreement.

(c) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing.

(d) In the event that this Agreement is terminated by:

(i) Buyer for any reason other than pursuant to Section 9.04(a)(ii) or Section 9.04(a)(iv);

(ii) by Seller pursuant to Section 9.04(a)(iii) due to the occurrence of any event or existence of any condition that causes Buyer to be unable to satisfy the conditions to the obligations of Seller to consummate the transactions contemplated by this Agreement as set forth in Sections 7.01, 7.04 or 7.05 (*provided,* that, with respect to Section 7.05, all closing conditions have been satisfied or waived, other than the conditions that by their terms are to be satisfied by actions to be taken at the Closing, provided that such actions are, as of the time of such termination, capable of being satisfied at the Closing); or

(iii) by Seller pursuant to Section 9.04(a)(iv) and at the time of such termination (x) all the conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Section 8 have been satisfied (other than the conditions that by their terms are to be satisfied by actions to be taken at the Closing, provided that such actions are, as of the time of such termination, capable of being satisfied at the Closing), and (y) Seller is in compliance in all material respects with the terms of this Agreement,

then Buyer shall, within five (5) business days after receipt of written notice of such termination, pay to Seller by wire transfer of immediately available funds to an account designated by Seller a fee equal to One Million Dollars ($1,000,000) (the "**Termination Fee**").

(e) This Section 9.04 shall survive any termination of this Agreement.

10. INDEMNIFICATION

10.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent provided in this Article 10, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any inaccuracy in or breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof;

(b) any claim asserted against Buyer or Buyer's Affiliates that, if meritorious, would constitute or give rise to a breach of any of Seller's representations and warranties as the direct cause of such claim;

(c) the nonfulfillment or breach of any covenant of Seller set forth in this Agreement or in any Closing Document to which Seller is a party;

(d) the Excluded Liabilities; and

(e) any claim made by a third party with respect to the operation of the Hospital Businesses prior to the Closing Date.

10.02. Seller's Limitations. Seller will have no liability under Section 10.01(a) and no claim will accrue against Seller under Section 10.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 10.01(a) exceeds $150,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's Indemnified Persons shall be entitled to indemnification for all Losses under Section 10.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Seller shall arise for all Losses, in respect of Losses resulting from Seller's intentional misrepresentation or fraud, *provided*, *further*, that Seller's liability for indemnification under Section 10.01(a) shall be limited to an amount equal to $3,000,000.

10.03. Indemnification by Buyer. Subject to the conditions and limitations, and solely to the extent, provided in this Article 10, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) the inaccuracy in or breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof;

(b) the nonfulfillment or breach of any covenant of Buyer in this Agreement or in any Closing Document to which Buyer is a party;

(c) the Assumed Liabilities; and

(d) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing Date.

10.04. Buyer's Limitations. Buyer will have no liability under Section 10.03(a) and no claim will accrue against Buyer under Section 10.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 10.03(a) exceeds $150,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 10.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Buyer, *provided, further*, that Buyer's liability for indemnification under Section 10.03(a) shall be limited to an amount equal to $3,000,000.

10.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this Article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 10 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a

reasonable summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within 60 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in this Section 10.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided*, *further*, that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 10.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons,

include both one or more of Buyer's Indemnified Persons and one or more of Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of Section 10.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided*, *however*, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld or delayed) and (B) the out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates).

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within 60 days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 60-day period in which to respond pursuant to Section 10.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall

reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be attempted to be resolved pursuant to Section 11.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within 10 days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 11.19.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 10.05(a)(i) and Section 10.05(b)(i), as applicable.

10.06. Survival of Representations and Warranties; Indemnity Periods. All of the representations, warranties, covenants, and agreements made by the parties in this Agreement or pursuant hereto in any certificate, instrument, or document shall survive the consummation of the transactions in the manner described herein, and may be fully and completely relied upon by Seller, Buyer, and PMH, as the case may be, notwithstanding any investigation heretofore or hereafter made by any of them or on behalf of any of them, and shall not be deemed merged into any instruments or agreements delivered at the Closing or thereafter. Each party acknowledges that no representations or warranties are made except as specifically set forth herein. Notwithstanding anything in this Section 10.06 that may be to the contrary, any claim, demand, or cause of action with respect to a breach of any representation or warranty made in this Agreement (other than representations or warranties contained in Sections 3.01 (Organization and Qualification), 3.02 (Corporate Powers; Absence of Conflicts, Etc), 3.03 (Binding Agreement), 3.04 (Investments and Third Party Rights), 3.10 (Title), 3.28 (Joint Ventures), 4.01 (Organization), 4.02 (Power and Authority; Due Authorization), 4.03 (Consents; Absence of

Conflicts, Etc.), 4.04 (Due Execution; Binding Agreement), which shall survive indefinitely, and the representations or warranties contained in Sections 3.05 (Legal and Regulatory Compliance), 3.12 (Environmental Laws), 3.16 Government Payment Programs; Accreditation; Payor Cost Reports), 3.21 (Employee Benefit Plans), 3.25 (Restricted Assets), and 3.23 (Taxes), which shall survive the longer of five (5) years or 90 days after the expiration of the applicable statute of limitations pertaining to the underlying claim, including extensions and waivers), must be made or brought, if at all, within eighteen (18) months after the Closing Date. For the avoidance of doubt, this Section 10.06 shall not affect any rights to bring claims after eighteen (18) months based on (a) any covenant or agreement of the parties that contemplates performance after the Closing, (b) the obligations of Seller under Sections 10.01(c), (d) and (e) (Indemnification by Seller), (c) the obligations of Buyer under Sections 10.03(b), (c) and (d) (Indemnification by Buyer), or (e) the obligations of the parties under Section 10.07 (Mitigation).

10.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any Third Party Claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

10.08. Calculation of Losses. Solely for the purpose of calculating the amount of any Losses arising out of or resulting from any breach of any representation or warranty contained in this Agreement (and not for determining the existence of any breach of any representation or warranty contained in this Agreement), any reference to a "material", "materiality" or "Material Adverse Effect" or other correlative terms in such representation or warranty shall be disregarded.

10.09. Seller's Failure to Pay for Certain Losses. If any Buyer's Indemnified Persons are entitled to indemnification for Losses pursuant to Section 10.01, and notice for indemnification of such Losses is provided by Buyer, in accordance with Section 10.05, prior to the third (3rd) anniversary after the Closing Date (including before the Closing Date), then to the extent that such Losses are not satisfied in full ("**Unpaid Losses**"), the Capital Amount shall be reduced by the aggregate amount of Unpaid Losses in accordance with Section 1.01(24).

11. GENERAL

11.01. Exhibits; Schedules. Each Exhibit and Schedule to this Agreement shall be considered a part hereof as if set forth herein in full.

11.02. Equitable Remedies. Each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 10).

11.03. Other Owners of Assets. Buyer, Seller and its undersigned Wholly Owned Subsidiaries acknowledge that certain Assets may be owned by Wholly Owned Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Wholly Owned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Wholly Owned Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Wholly Owned Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Wholly Owned Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement.

11.04. Dispute Resolution. The parties hereby agree that, prior to pursuing any other legal remedy, any controversy or claim arising out of this Agreement shall be attempted to be resolved through the following procedures:

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party written notice of such dispute pursuant to Section 11.14, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 11.04(a) within 30 days of the written notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within 15 days after receipt of written notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

11.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

11.06. Reproduction of Documents. This Agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

11.07. Consented Assignment. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Assumed Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller shall cooperate in any reasonable arrangement designed to provide for Buyer the benefits under any such Assumed Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise but shall not be required to commence litigation. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such Assumed Contract, claim or right; *provided*, *however*, that such obligation shall be of no further force and effect if Seller and Buyer determine that such consent or approval will not be forthcoming.

11.08. Time of Essence. Time is of the essence in the performance of this Agreement, *provided* that, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Manchester, Connecticut are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Waterbury, Connecticut are permitted or required to be closed. The parties will use commercially reasonable efforts to file as soon as practicable and pursue all necessary regulatory approvals required in connection with this Agreement.

11.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

11.10. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any litigation or proceedings among the parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

11.11. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate one or more Affiliates to purchase any or all of the Assets, including the Hospital Businesses, provided that PMH shall unconditionally guarantee any and all obligations of such Affiliates pursuant to Section 11.22, and (ii) Buyer and PMH shall be permitted to grant a security interest in and collaterally assign and transfer all their rights, interests and benefits, but not their obligations, under this Agreement to any entity providing financing to Buyer and/or Buyer's Affiliates at any time and from time to time without obtaining the written consent of Seller.

11.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms.

11.13. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by the other party of any provision of this Agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this Agreement, or (c) any other right or remedy permitted the waiving party in this Agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by the party entitled to the benefit of the provision, condition, right or remedy to be waived, and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies.

11.14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) three (3) days after the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: c/o Prospect Medical Holdings, Inc.
Prospect Medical Holdings, Inc.
3415 South Sepulveda Boulevard, 9th Floor
Los Angeles, CA 90034
Attn: General Counsel
Fax: 310-943-4501
Email: ellen.shin@prospectmedical.com

with a copy to (which shall not constitute notice):

Epstein Becker & Green, P.C.
1 Gateway Center
Newark, NJ 07102
Attn: Gary W. Herschman
Email: GHerschman@ebglaw.com
Attn: David E. Weiss
Email: DWeiss@ebglaw.com

If to Seller: Greater Waterbury Health Network, Inc.
Attn: President
Fax: 203-573-6161
Email: dstromstad@wtbyhosp.org

with a copy to (which shall not constitute notice):

Carmody Torrance Sandak & Hennessey, LLP
707 Summer Street, Suite 300
Stamford, CT 06901

Attn: Ann Zucker, Esq.
Fax: 203.252.2686
Email: azucker@carmodylaw.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section.

11.15. Severability. If any provision of this Agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this Agreement would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; (c) the remainder of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this Agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

11.16. CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate Governmental Authority shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

11.17. Entire Agreement; Amendment. Except as set forth in Section 11.21(a), this Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 10.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

11.18. Counterparts; Transmission by Electronic Means. 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. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

11.19. Interest. Any monies required to be paid by any party to another party pursuant to this Agreement shall be due on the date or at the time for payment specified in this Agreement, and monies not paid when due shall accrue interest from and after the due date to, but not including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A. during such period.

11.20. Drafting. No provision of this Agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this Agreement.

11.21. Fees and Expenses.

(a) Except as otherwise expressly set forth in this Agreement and the Letter of Intent, dated April 30, 2015, by and between Seller and PMH, whether or not the transactions contemplated by this Agreement are consummated, (i) Buyer or its Affiliates shall bear and pay all expenses incurred by or on behalf of Buyer in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Agreement and Buyer's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) Seller shall bear and pay all expenses incurred by or on behalf of Seller, or its Affiliates or Wholly Owned Subsidiaries, in connection with the preparation and negotiation of this Agreement and Seller's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than $1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all transfer Taxes, sales and use and similar Taxes arising out of the transfer of the Assets (whether or not originally arising

with or assessed to Seller or its applicable Wholly Owned Subsidiary) and (iii) the premium for Buyer's title insurance policies described in Section 8.08.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Agreement and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

11.22. Guarantee of Buyer's Obligations. PMH, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, PMH will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 10.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. PMH obligations under this Section 11.22 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

11.23. Liquidated Damages.

(a) The parties acknowledge that: (i) the agreements contained in Section 9.04(d) are an integral part of the transactions contemplated by this Agreement; (ii) without these agreements, the parties would not enter into this Agreement; (iii) it would be extremely difficult and impracticable, if not impossible, to ascertain with any degree of certainty the amount of damages that would be suffered by Seller in the circumstances in which the Termination Fee is payable; and (iv) the Termination Fee is not a penalty, but rather is liquidated damages in a reasonable amount, negotiated as the parties' reasonable estimate of Seller's damages in the circumstances in which the Termination Fee is payable. Notwithstanding anything to the contrary in this Agreement, Seller's right to receive payment of the Termination Fee pursuant to Section 9.04(d) shall be the sole and exclusive remedy of Seller or any of its Affiliates against Buyer, PMH or any of their respective Affiliates or any of their respective stockholders, partners or members for any and all losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with Section 9.04(d), none of Buyer, PMH or any of their respective Affiliates or any of their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(b) If Buyer fails to pay the Termination Fee pursuant to Section 9.04(d) when due and, in order to obtain such payment, Seller commences a suit or suits that result in a judgment or judgments against Buyer for the Termination Fee, then Buyer shall pay to Seller its costs and expenses (including attorneys' fees and expenses) in connection with such suit and the collection and enforcement of such judgment(s), together with interest on the amount of the Termination Fee from the date such payment was required to be made until the date of payment at the "prime rate" of Bank of America, N.A. in effect on the date such payment was required to be made.

[*Signature Page Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____

Name: Darlene Stromstad
Title: President and Chief Executive Officer

PROSPECT CT MEDICAL FOUNDATION, INC.

By: _____

Name: Samuel S. Lee
Title: President

PROSPECT WATERBURY, INC.

By: _____

Name: Samuel S. Lee
Title: President

PROSPECT WATERBURY HOME HEALTH, INC.

By: _____

Name: Samuel S. Lee
Title: President

PROSPECT MEDICAL HOLDINGS, INC.
(only with respect to Section 11.22)

By: _____

Name: Samuel S. Lee
Title: Chief Executive Officer

[*Acknowledgement Page Follows*]

Each of the undersigned Wholly Owned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 11.03.

ACKNOWLEDGED BY:

THE WATERBURY HOSPITAL

By: _____

Name: Darlene Stromstad

Title: President and Chief Executive Officer

VNA HEALTH AT HOME, INC.

By: _____

Name: Sandra Iadarola

Title: Chairperson

GREATER WATERBURY MANAGEMENT RESOURCES, INC.

By: _____

Name: Mark Holtz

Title: President

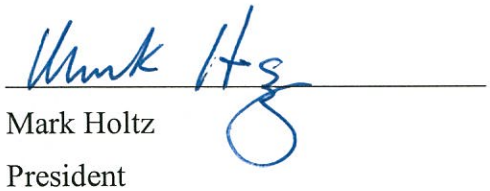
ALLIANCE MEDICAL GROUP, INC.

By: _____

Name: David MacDonald

Title: President

CARDIOLOGY ASSOCIATES OF GREATER WATERBURY, LLC

By: 

Name: Mark Holtz

Title: President

Exhibit A

Form of Transitional Services Agreement

See attached.

TRANSITION SERVICES AGREEMENT

This Transition Services Agreement (this "Agreement") is made and entered into as of the 1st day of October, 2016, by and between Greater Waterbury Health Network, Inc. (together with affiliates and successors, collectively, "OLDCO") and Prospect Waterbury, Inc. (together with affiliates and successors, collectively, "Prospect").

W I T N E S S E T H

WHEREAS, at a closing held on the date hereof pursuant to that certain Asset Purchase Agreement, dated September 27, 2016,by and among, Inter Alia, Prospect and OLDCO (the "Purchase Agreement"), Prospect has acquired substantially all of the assets of OLDCO; and

WHEREAS, Prospect has employed substantially all of the former employees of OLDCO;

WHEREAS, following the closing under the Purchase Agreement, Greater Waterbury Health Network, Inc. and certain of its affiliates will change their respective names to new names that are not confusingly similar to the names being used by Prospect;

WHEREAS, OLDCO, requires certain post-closing services to wind down its business, administer the assets not sold to Prospect and discharge the liabilities of OLDCO not assumed by Prospect; and

WHEREAS, Prospect is willing to provide those certain services to OLDCO for such purposes during the term of this Agreement.

NOW THEREFORE, in consideration of the foregoing and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Term. The term of this Agreement shall commence on the date hereof and shall continue for a period of 36 months (the "Term"). The Term may be extended for a mutually agreeable period if necessary to complete any ongoing Transition Services (hereinafter defined).

2. Transition Services. During the Term, Prospect shall arrange for services to be provided to OLDCO in the manner detailed in Exhibit A (the "Transition Services").

a. Prospect will provide the Transition Services in good faith and with due care consistent with the care Prospect exercises in performing like services for itself. Prospect shall provide the Transition Services in a manner that will permit the timely filing of all governmental forms and filings in order to permit the orderly wind-down of OLDCO. OLDCO acknowledges and agrees that Prospect does not regularly provide the Transition Services to third parties as part of its business, and, except as specifically stated elsewhere herein, Prospect

does not otherwise warrant or assume any responsibility for its performance of the Transition Services.

b. Prospect shall have no obligation to provide any Transition Services in any instance where such Transition Services would create a conflict of interest between Prospect and OLDCO. Prospect at its sole discretion, shall be permitted to identify instances of conflicts of interest between Prospect and OLDCO.

c. OLDCO shall have no obligation to accept any Transition Services in any instance where such Transition Services would create a conflict of interest between Prospect and OLDCO. OLDCO at is sole discretion, shall be permitted to decline any Transition Services from Prospect in instances where a conflict of interest is identified by OLDCO.

d. OLDCO shall initially appoint James Moylan as representative of OLDCO following the Closing (the "Representative"). The Representative shall be the principal contact person and shall have the authority and be responsible for making decisions on behalf of OLDCO under this Agreement. The Representative shall be authorized to sign documents (including checks) on behalf of OLDCO and take all other appropriate and necessary actions on behalf of OLDCO.

e. Each party shall make available to the other party any information required or reasonably requested by that other party regarding performance of Transition Services, and shall be responsible for timely providing that information and for the accuracy and completeness of that information. The parties shall cooperate with each other in good faith in all matters relating to the provision and receipt of Transition Services. The parties shall cooperate with each other in making such information available as needed in the event of any and all internal and external audits. If this Agreement is terminated in whole or in part, the parties shall cooperate with each other in all reasonable respects in order to effect an efficient transition and to minimize disruption to the business of both parties.

3. Charges; Payment Terms.

a. OLDCO shall, for each Transition Service performed, reimburse Prospect for any reasonable documented out-of-pocket expenses that are incurred by Prospect in connection with Prospect's provision of the Transition Services ("Expenses"). Prospect shall provide OLDCO with an invoice for all Transition Services provided at the rates described on Exhibit B, and Expenses incurred by Prospect in connection therewith, during the Term, that are payable by OLDCO pursuant to this Agreement, together with all appropriate supporting documentation (each, an "Invoice").

b. OLDCO shall, subject to Section 2.05(l)(i) of the Purchase Agreement, pay in full to Prospect all fees and Expenses as set forth in the Invoice within thirty (30) days after receipt of the Invoice.

c. If Prospect terminates any of the Transition Services prior to the expiration of the Term, OLDCO shall be responsible for payment only for the Transition Services provided through the date on which such Transition Services are terminated.

d. If OLDCO exhausts its funds such that it can no longer pay for the Transition Services, Prospect shall continue to provide those Transition Services that are necessary for the timely filing of all governmental forms and filings in order to permit the orderly wind-down of OLDCO and shall not seek payment from OLDCO for such Transition Services.

4. Indemnification.

a. Each party assumes liability for and shall indemnify and hold harmless the other party, its officers, directors, trustees, employees, and agents, from and against any and all losses, damages, penalties, liabilities, claims, actions, suits, costs, and expenses, including reasonable attorneys' fees, whether in law or in equity, of any kind or nature whatsoever, imposed upon, incurred by, or asserted against the other party relating to or arising out of any negligent or other wrongful act or omission of such party, its employees or agents, or any breach of this Agreement by such party.

b. Neither party shall have liability for consequential, exemplary, indirect, special, incidental or punitive damages, including loss of profits, revenues, data or use, incurred by the other party, whether based on contract, tort or any other legal theory, arising out of or related to this Agreement or the Transition Services provided hereunder.

c. Notwithstanding anything contained herein to the contrary, any liability of a party under this Agreement shall in no event exceed the aggregate amount of fees paid to Prospect by OLDCO hereunder, except in the case of such party's gross negligence or reckless or intentional act or omission.

d. The provisions of this Section 4 shall survive the termination of this Agreement.

5. Confidentiality.

a. "Confidential Information" is defined as all information, data and materials furnished or made available by a party to another party in connection with this Agreement, including, without limitation, the identity of patients, the content of any medical records, financial and tax information, and information regarding Medicare and Medicaid claims submission and reimbursements.

b. The party receiving the Confidential Information (the "Receiving Party") from the party who owns or holds in confidence such Confidential Information (the "Owning Party") may use the Confidential Information solely for the purpose of performing its obligations or enforcing its rights under this Agreement.

c. The Receiving Party shall not disclose any of the Confidential Information except to those persons having a need to know for the purpose of performing the Receiving Party's obligations or enforcing its rights under this Agreement. Each party shall take appropriate action, by instruction to or agreement with its affiliates, employees, agents and

subcontractors, to maintain the confidentiality of the Confidential Information. The Receiving Party shall promptly notify the Owning Party in the event that the Receiving Party learns of an unauthorized release of Confidential Information.

d. The Receiving Party shall have no obligation with respect to (i) Confidential Information made available to the general public without restriction by the Owning Party or by an authorized third party; (ii) Confidential Information known to the Receiving Party independently of disclosures by the Owning Party under this Agreement; (iii) Confidential Information independently developed by the Receiving Party; or (iv) Confidential Information that the Receiving Party may be required to disclose pursuant to subpoena or other lawful process; provided, however, that the Receiving Party notifies the Owning Party in a timely manner to allow the Owning Party to protect its interests.

e. Upon the termination or expiration of this Agreement, each party shall (a) immediately cease to use the other party's Confidential Information and (b) return to the other party such Confidential Information and all copies thereof within ten (10) days of the termination, unless otherwise provided in this Agreement.

f. The parties acknowledge that monetary remedies may be inadequate to protect rights in Confidential Information and that, in addition to legal remedies otherwise available, injunctive relief is an appropriate judicial remedy to protect such rights. The provisions of this Section 5 shall survive the termination of this Agreement.

6. Protected Health Information.

a. Each of Prospect and OLDCO shall comply with all federal and state laws and regulations, regarding the confidentiality of protected health information. Simultaneously herewith, the parties shall enter into a Business Associate Agreement in accordance with the applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320, and the requirements of the regulations promulgated thereunder (45 C.F.R. Parts 160, 162, and 164) as amended by the Health Information Technology for Economic and Clinical Health Act found in the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, Title XIII (2009, aka HITECH), including regulations promulgated thereunder, as amended, and guidance issued pursuant thereto (collectively "HIPAA"). In addition, each of Prospect and OLDCO acknowledges that in receiving or otherwise dealing with any records or information from the other about patients receiving treatment for alcohol or drug abuse, Prospect and OLDCO respectively and their respective staffs are bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, as amended from time to time.

b. To the extent that any records maintained or stored by either Prospect or OLDCO pursuant to this Agreement contain Personal Information (as herein defined) about their respective personnel or patients, they shall comply with Rhode Island General Laws 11-49.2-1 et seq. ("Identity Theft Protection Act of 2005"). "Personal Information" shall mean: (a) first name or first initial and last name in combination with any one or more of the following data elements

when either the name or the data elements are not encrypted: (i) Social Security number; (ii) driver's license or Identification Card Number; or (iii) account number, credit or debit card number in combination with any required security code, access code or password that would permit access to an individual's financial account. In the event of a breach of the security of the system involving such records, Prospect or OLDCO, as the case may be, shall immediately notify the other via telephone and in writing and shall comply fully with the Identity Theft Protection Act of 2005. For purposes of this paragraph, the term breach of the security system shall mean: (a) the unauthorized acquisition of unencrypted computerized data that compromises the security, confidentiality or integrity of personal information; or (b) any other unauthorized use or acquisition of, or access to, Personal Information. The provisions of this paragraph shall survive the termination of this Agreement.

7. Record Retention. Until the expiration of four years after the termination of this Agreement, the Parties upon request shall make available to the Secretary, United States Department of Health and Human Services, the U.S. Comptroller General or any of their duly authorized representatives, this Agreement and all other books, documents, and records necessary to certify the nature and extent of the costs incurred by the Parties under this Agreement. If a party purchases such services through a subcontract worth Ten Thousand Dollars ($10,000) or more over twelve (12) month period with a related organization, the subcontract shall also contain a clause permitting access by said Secretary, Comptroller General, and their respective representatives to the books and records of the related organization. Each party shall promptly notify the other via telephone and in writing if such access is requested.

8. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to its conflict of law provisions. Each party hereby consents to jurisdiction in the State of Connecticut should suit to enforce this contract become necessary. If either party hereto shall bring suit to enforce the terms and provisions hereof or to recover damages for breach, the prevailing party shall be entitled to recover from the other party all costs, expenses and attorneys' fees incurred in connection with the exercise by the prevailing party of its rights and remedies hereunder.

9. Termination.

a. This Agreement may be terminated by OLDCO immediately upon the occurrence of any of the following events:

i. the failure of Prospect to cure any material default hereunder after thirty days' notice;

ii. the loss or suspension of any license necessary for Prospect to fulfill its obligations hereunder;

iii. the loss of Prospect's liability insurance;

iv. Prospect is restricted from participating in the Medicare or Medicaid programs;

v. a "bankruptcy event." For purposes of this Section 9, "bankruptcy event" shall mean if a receiver, liquidator or trustee is appointed for Prospect or if Prospect is adjudicated a bankrupt or insolvent, or if any petition for bankruptcy, reorganization or arrangement pursuant to state or federal bankruptcy law is filed by or against, consented to, or acquiesced in by Prospect or if any proceeding for the dissolution or liquidation of Prospect is instituted; however, if such action was involuntary, upon the same not being discharged, stayed or dismissed within 60 days.

b. OLDCO may terminate this Agreement prior to the expiration of the Term by giving Prospect at least thirty (30) days prior written notice of termination. Subject to Section 3.d., Prospect may terminate this Agreement prior to the expiration of the Term upon at least 60 days' notice in the event that OLDCO has failed to pay any Invoice when due, unless the Expenses reflected on such Invoice are being disputed in good faith by OLDCO.

10. Miscellaneous.

a. Any notice or other communication under this Agreement shall be in writing and shall be deemed to have been given: (a) upon actual delivery, if delivered by hand; (b) the first business day following deposit with any nationally recognized overnight carrier; or (c) three (3) days after deposit in the United States mail, postage prepaid, certified or registered mail, return receipt requested. Each such notice shall be sent to the parties, marked to the attention of the signatories to this Agreement, at the following addresses:

If to Prospect: Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708
Attention: CEO

With a copy to: Prospect Medical Holdings, Inc.
3415 South Sepulveda Boulevard, 9th Floor
Los Angeles, California 90034
Attention: Legal Department

If to OLDCO: Legacy GWHN, Inc.
c/o Carmody Torrance et al
50 Leavenworth Street
Waterbury CT 06702
Attention: James Moylan

b. The parties agree that the relationship between them shall be that of independent contractors. Neither party shall hold itself out as the employee, agent, joint venturer or partner of the other. Neither party has the authority to bind the other in any way. Prospect is responsible for paying or withholding, as required, federal, state, and local employment taxes including, without limitation, FICA and FUTA, for its employees.

c. This Agreement contains the entire agreement of the parties with respect to the matters set forth herein and may not be amended except in writing signed by all of parties hereto.

d. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns. A party shall not assign its rights and obligations under this Agreement without the other party's prior written consent, which shall not be unreasonably withheld.

e. No delay or failure by either party to exercise any right under this Agreement, and no partial or single exercise of that right, shall constitute a waiver of that or any other right at any time, or from time to time thereafter. The waiver of any breach of any term or condition of this Agreement shall not be deemed to constitute the continuing waiver of the same or any other term or condition.

f. If any part of this Agreement should be held to be void or unenforceable, such part shall be treated as severable, leaving valid the remainder of this Agreement, notwithstanding the part or parts found to be void or unenforceable.

g. Headings in this Agreement are for convenience only and shall not be used to interpret or construe its provisions.

h. This Agreement may be executed by facsimile signature and in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the parties have executed this Transition Services Agreement as of the date first written above.

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____
Name: _____
Title: _____

PROSPECT WATERBURY, INC.

By: _____
Name: _____
Title: _____

EXHIBIT A

Services

The services to be provided by Prospect to OLDCO may include but not be limited to:

Accounting:

- Monthly financial close
- Management of cash and investment activities as necessary
- Preparation of tax returns
- Monthly reconciliation of balance sheet accounts
- Financial audits including 403b
- Assistance with the final preparation and submission of the *Cy Pres* Application
- Assist with appealing and resolving RAC appeals

Accounts Payable:

- Entry and payment of invoices as necessary
- Creation of 1099s through February of 2017
- Assistance with reconciliation of outstanding checks

Payroll:

- Filing of payroll tax reports as necessary
- Creation of W-2's for pre-transition employees
- Management of outstanding checks
- Employee support - providing information to employees for historical payroll data, historical W-2 requests and payroll slips

Human Resources:

- Response to prior plan inquiries

Miscellaneous:

- Assist in Preparation of 990 tax returns
- Assist in Preparation of the Community Needs Assessment (990 reporting requirement)
- Insurance management
- Assist in the planning of and transition to Post-Agreement operations
- Assist in developing a plan for Post-Agreement office space
- Assist with record retention planning
- Assist with necessary reporting to regulatory authorities
- Assist with any OHCA or AG mandated reporting

Information Services:

- Assist with support of OLDCO systems, including backup, for all necessary applications, and custom reports as needed

- Maintain and protect all data to meet OLDCO's data retention requirements
- Support all audits/reviews of data

Legal/Risk Management:

- Assist with operational issues
- Assist with resolution of outstanding claims and suits, including prior workers compensation claims
- Assist with the withdrawal of the hospital from HAIC, if necessary

EXHIBIT B

Rates

1. Scott Bowman – One Hundred Fifteen Dollars ($115.00) per hour
2. Kathy Buckley – Eighty-Five Dollars ($85.00) per hour
3. Prospect personnel at the level of Vice President and above shall be provided at the rate of One Hundred Fifty Dollars ($150) per hour.
4. All other Prospect personnel shall be provided at the rate of Ninety Dollars ($90) per hour.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into and made effective as of October 1, 2016 (the "Effective Date") by and between Prospect Waterbury, Inc. and its subsidiaries (collectively "Prospect"), on the one hand, and Greater Waterbury Health Network, Inc., and its subsidiaries and successors (collectively, "OLDCO"), on the other.

RECITALS

A. Prospect and OLDCO have entered into various agreements, including a Transition Services Agreement, (collectively the "Underlying Contracts") pursuant to which the parties may disclose certain information to one another pursuant to the terms of the Underlying Contracts, some of which may constitute Protected Health Information ("PHI" or "Protected Information") (defined below).

B. Prospect and OLDCO intend to protect the privacy and provide for the security of PHI disclosed to one another and are committed to complying with the patient privacy requirements set forth in California law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and all regulations promulgated by the U.S. Department of Health and Human Services under HIPAA and the HITECH Act, including the requirements set forth in the HIPAA Final Omnibus Rule issued on January 25, 2013, ("HIPAA Regulations").

C. As part of the HIPAA Regulations, the Privacy, Security, Breach Notification, and Enforcement Rules (defined below as "HIPAA Rules") require the parties to enter into an agreement containing specific requirements concerning the disclosure of PHI, as required by Code of Federal Regulations ("C.F.R.), Title 45, Parts 160 and 164.

In consideration of the mutual promises contained herein and the exchange of information pursuant to this Agreement, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. *DEFINITIONS*

All capitalized terms used herein but not otherwise defined in this Agreement shall have the same meaning as in the HIPAA Rules.

a. **Breach** shall have the meaning given to such term under the HIPAA Rules.

b. **Business Associate** ("BA") shall have the meaning given to such term under the HIPAA Rules, as set forth in 42 U.S.C. § 17938 and 45 C.F.R. § 160.103, and, in reference to this Agreement, shall mean either Prospect or OLDCO, depending on which party is receiving the protected information, and the subcontractors, agents, and person(s) or entities under the party's control.

c. **Covered Entity** ("CE") shall have the meaning given to such term under the HIPAA Rules, as set forth in C.F.R. § 160.103. Both Prospect and OLDCO are Covered Entities and may provide protected information to the other party, which will sit in the role as the Business Associate.

d. **Data Aggregation** shall have the meaning given to such term under the HIPAA Rules, as set forth 45 C.F.R. § 164.501.

e. **Designated Record Set** shall have the meaning given to such term under HIPAA Rules, as set forth in 45 C.F.R. § 164.501.

f. **Electronic Protected Health Information or EPHI** means Protected Health Information that is maintained in or transmitted by electronic media, as defined in the HIPAA Rules.

g. **Electronic Health Record** shall have the meaning given to such term in the HIPAA Rules and as set forth in 42 U.S.C. § 17921.

h. **Health Care Operations** shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, the meaning set forth in 45 C.F.R. § 164.501.

i. **HIPAA Rules** shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and 164.

j. **Protected Health Information or PHI** shall have the meaning given to such term under the HIPAA Rules, including 45 C.F.R. § 160.103, which includes any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information includes Electronic Protected Health Information.

k. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

l. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate, pursuant to 45 C.F.R. § 160.103.

m. **Unsecured PHI** shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to that issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("Secretary").

2. *OBLIGATIONS OF BUSINESS ASSOCIATE*

a. **Permitted Access, Use or Disclosure.** The parties shall neither permit the unauthorized or unlawful access to, nor use or disclose, PHI other than as permitted or required by the Underlying Contracts, this Agreement or as permitted or required by law. The parties shall not access, use or disclose Protected Information in any manner that would constitute a violation of HIPAA, the HITECH Act, the HIPAA Regulations, or applicable state law if so accessed, used or disclosed by CE. However, the parties may access, use or disclose Protected Information (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; (iv) for Data Aggregation purposes for the Health Care Operations of CE; (v) for the public health activities and purposes set forth at 45 C.F.R. § 164.512(b); or (vi) to the extent such Protected Information is de-identified in accordance with the standards set forth under 45 C.F.R. § 164.514, provided the parties have each other's written consent in advance of any such use or disclosure, which consent may be withheld in CE's sole discretion. If either party permits a third party to use or access Protected Information or otherwise discloses Protected Information to a third party, the party must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Agreement and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify the other party of any Breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such Breach.

b. **Prohibited Uses and Disclosures under HITECH**. Notwithstanding any other provision in this Agreement, the parties to this Agreement shall comply with the following requirements: (i) a party shall not use or disclose Protected Information for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of 42 U.S.C. 17936, 45 C.F.R. § 164.522(a)(vi); (ii) a party shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); (iii) a party shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HIPAA Rules and HITECH Act, 42 U.S.C. § 17935(d)(2), 45 C.F.R. 164.502(a)(5)(ii); however, this prohibition shall not affect payment for services provided pursuant to the Agreement.

c. **Appropriate Safeguards**. The parties shall implement appropriate safeguards as are necessary to prevent the access, use or disclosure of Protected Information other than as permitted by the Underlying Contracts or this Agreement. The parties shall comply, where applicable, with the Security Rule with respect to EPHI, including but not limited to 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements of the HIPAA Security Rule set forth in 45 C.F.R. § 164.316, and shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI.

d. **Mitigation**. The parties agree to mitigate, to the extent practicable, any harmful effect that is known as a result of use or disclosure of PHI not authorized by the Underlying Contracts, this Agreement or applicable federal or state rules or regulations governing the use, access, maintenance or disclosure of protected health information.

e. **Reporting of Improper Access, Use or Disclosure**. The parties shall promptly report to the other party in writing of any access, use or disclosure of Protected Information exchanged between one another, not permitted by the Underlying Contracts, this Agreement, the HIPAA Rules or any corresponding state privacy or security requirements as well as any security incident of which it becomes aware. The parties shall, following the discovery of any Breach of Unsecured PHI, notify the other in writing of such breach without unreasonable delay and in no case later than ten (10) calendar days after discovery. The party responsible for the improper use or disclosure agrees to pay the actual, reasonable costs of the required notifications.

f. **Business Associate's Subcontractors**. The receiving party of any protected information shall ensure that any Subcontractors that create, maintain or transmit Protected Information, agree in writing to the same restrictions and conditions that apply to the party with respect to such PHI. To the extent a party creates, maintains, receives or transmits Electronic PHI on behalf of the other party, the receiving party shall implement the safeguards required by paragraph 2.c. above with respect to EPHI and shall ensure that any Subcontractor to whom it provides Protected Information agrees in writing to implement the same safeguards.

g. **Access to Protected Information**. To the extent the receiving party maintains a Designated Record Set on behalf of the other party, it shall make Protected Information maintained by it or its Subcontractors in Designated Record Sets available to the other party for inspection and copying within fifteen (15) days of a request by the other party to enable the other party to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If the receiving party maintains an Electronic Health Record, the receiving party shall provide such information in electronic format to enable the CE to fulfill its obligations under the HIPAA Rules (and the HITECH Act as set forth in 42 U.S.C. § 17935(e)).

h. **Amendment of PHI.** To the extent a party maintains a Designated Record Set on behalf of the other party, within fifteen (15) days of receipt of a request from the other party or an individual for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, the party and/or its Subcontractors shall make any amendments that the other party directs or agrees to in accordance with the HIPAA Rules.

i. **Accounting Rights**. Within fifteen (15) days of notice by a party of a request for an accounting of disclosures of Protected Information, each party and its Subcontractors shall make available to the requesting party the information required to provide an accounting of disclosures to enable the party to fulfill its obligations under the HIPAA Rules, including, but not limited to, 45 C.F.R. § 164.528 and 42 U.S.C. § 17935(c), as determined by the requesting party. The provisions of this subparagraph 2.i. shall survive the termination of this Agreement.

j. **Governmental Access to Records**. The parties shall make their internal practices, books and records relating to the use and disclosure of Protected Information available

to the other party and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining the party's compliance with the HIPAA Rules. Each party shall immediately notify the other party of any requests made by the Secretary and provide the other party with copies of any documentation it provides in response to such requests.

k. **Compliance with Privacy Rule.** To the extent that a party carries out the other party's obligations under the Privacy Rule, the party shall comply with the requirements of the Privacy Rule that apply to the other party in the performance of such obligations.

l. **Minimum Necessary**. Each party and their respective Subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure. The parties understand and agree that the definition of "minimum necessary" shall be the meaning set forth in the HIPAA Rules. The parties agree to make their respective uses, disclosures and requests for Protected Information consistent with the other party's minimum necessary policies and procedures, to the extent such policies and procedures are provided to one another.

m. **Business Associate's Insurance**. The parties shall each obtain insurance for themselves and their respective employees, agents and independent contractors in an amount not less than One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate of Commercial General Liability insurance and Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Errors and Omissions insurance. The Errors and Omissions insurance shall cover, among other things, Breaches. Upon request, the parties shall exchange certificates of insurance or other written evidence of the insurance policy or policies required herein prior to execution of this Agreement (or as shortly thereafter as is practicable) and as of each annual renewal of such insurance policies during the period of such coverage. Further, in the event of any material modification, termination, expiration, non-renewal or cancellation of any of such insurance policies, the party shall give written notice to the other party not more than ten (10) days following the party's receipt of such notification. If a party fails to procure, maintain or pay for the insurance required under this section, the other party shall have the right, but not the obligation, to obtain such insurance. In such event, the party shall promptly reimburse the other party for the cost thereof upon written request, and failure to repay the same upon demand by the party shall constitute a material breach of this Agreement.

3. *TERMINATION*

a. **Term.** The term of this Agreement shall be effective as of the Effective Date and shall terminate upon the later of (1) the termination or expiration of the Underlying Contracts; or (2) when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

b. **Termination**.

i. **Material Breach**. A breach by either party of any provision of this Agreement, as determined by the other party, shall constitute a material breach of the Agreement

and shall provide grounds for termination of the Agreement, any provision in the Agreement to the contrary notwithstanding, with or without an opportunity to cure the breach. If termination of the Agreement is not feasible, the party may report the problem to the Secretary.

ii. **Material Breach by either CE**. If either party knows of a pattern of activity or practice of the other party that constitutes a material breach or violation of the other party's obligations under the Underlying Contracts, the Agreement or other arrangement, the party shall notify the other party of the pattern or activity or practice and take reasonable steps to assist the other party in curing or ending the breach or violation. If the steps are unsuccessful, the party may be required terminate the Agreement or other arrangement.

c. **Effect of Termination**. Upon termination of the Agreement for any reason, the parties shall, at the option of the other party, return or destroy all Protected Information or its Subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by a party, the other party shall continue to extend the protections of this Agreement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. If a party elects destruction of the PHI, the party shall certify in writing to the other party that such PHI has been destroyed.

4. ***INDEMNIFICATION; LIMITATION OF LIABILITY***. To the extent permitted by law, a party shall indemnify, defend and hold harmless the other party and its directors, officers, employees, parent, subsidiaries, agents and affiliates from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of the indemnifying party in connection with the representations, duties and obligations of the indemnifying party under this Agreement. Any limitation of liability contained in the Agreement shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of the Agreement.

5. ***ASSISTANCE IN LITIGATION***. Each party shall make itself and any Subcontractors assisting a party in the performance of its obligations pursuant to the Underlying Contracts available, at no cost to the other party, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against a party, its directors, officers, agents, employees or affiliates based upon a claim of violation of the HIPAA Rules or HITECH Act, or other California or federal laws related to security and privacy, except where the party or its Subcontractor is named as an adverse party.

6. ***COMPLIANCE WITH STATE LAW.*** Nothing in this Agreement shall be construed to require or permit either party to use or disclose Protected Information without a written authorization from an individual who is a subject of the Protected Information, or without written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

7. ***AMENDMENT TO COMPLY WITH LAW***. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such develop-

ments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that they must receive satisfactory written assurance from the other party that it will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act or any other applicable law. A party may terminate the Agreement upon thirty (30) days written notice if (i) the other party does not promptly enter into negotiations to amend the Agreement or Agreement when requested by a party pursuant to this section or (ii) the other party does not enter into an amendment to the Underlying Contracts or Agreement providing assurances regarding the safeguarding of PHI that the other party, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

8. ***NO THIRD-PARTY BENEFICIARIES***. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person other than the parties to this Agreement and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

9. ***INTERPRETATION***. The provisions of this Agreement shall prevail over any provisions in the Underlying Contracts that may conflict or appear inconsistent with any provision in this Agreement. This Agreement and the Underlying Contracts shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, and any other state or federal rules concerning PHI. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules. Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the Agreement shall remain in force and effect.

10. ***NOTICES.*** All notices hereunder shall be in writing and delivered by a confirmed facsimile, personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered by fax, personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to Prospect

Prospect Waterbury, Inc.
Attn: Chief Executive Officer
64 Robbins Street
Waterbury, CT 06708
Fax: [_____]

and

Prospect Medical Holdings, Inc.
Attn: Legal Department
3415 South Sepulveda Blvd, Suite 400, Los Angeles, CA 90034
Fax: (310) 943-4501

If to OLDCO

Legacy Waterbury Hospital, Inc.
Attn: James Moylan
c/o Carmody Torrance et al
50 Leavenworth Street
Waterbury CT 06702

or to such other persons or places as either party may from time to time designate by written notice to the other.

11. ***ENTIRE AGREEMENT OF THE PARTIES.*** This Agreement supersedes any and all prior and contemporaneous business associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which is not embodied herein. No other agreement, statement or promise, with respect to the subject matter hereof, not contained in this Agreement shall be valid or binding.

12. ***REGULATORY REFERENCES***. A reference in this Agreement to a section of regulations means the section as in effect or as amended, and for which compliance is required.

13. ***COUNTERPARTS.*** This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Effective Date referenced above.

PROSPECT WATERBURY, INC.	**GREATER WATERBURY HEALTH NETWORK, INC.**
By: _____	By: _____
Name:	Name:
Title:	Title:

Exhibit B

Form of Limited Power of Attorney

See attached.

EXECUTION VERSION

THE WATERBURY HOSPITAL
(a Connecticut nonstock corporation)

LIMITED POWER OF ATTORNEY

The Waterbury Hospital, a Connecticut nonstock corporation ("Registrant"), operates under the certain licenses and registrations relating to controlled substances and the operation of pharmacies and laboratories set forth on Exhibit A hereto (collectively, the "Licenses and Registrations"). This Limited Power of Attorney is being delivered pursuant to that certain Asset Purchase Agreement, dated as of September 27, 2016, by and among Registrant, Prospect Waterbury, Inc., a Connecticut corporation ("Corporation"), and certain other parties (the "Purchase Agreement").

1. To the extent permitted by applicable law:

(a) I, Darlene Stromstad, am authorized to sign the current applications for DEA registration on behalf of the Registrant under the Controlled Substances Act or Controlled Substances Import and Export Act, and have made, constituted, and appointed, and by these present, do hereby make, constitute, and appoint Corporation as my true and lawful attorney-in-fact to act for me in my name, place, and stead, to execute applications for Forms 222 and to sign orders for Schedule II controlled substances, whether these orders be on Form 222 or electronic, in accordance with 21 U.S.C. § 828 and Part 1305 of Title 21 of the Code of Federal Regulations, for the Limited Period described in Section 3 below. I hereby ratify and confirm all that Corporation must lawfully do or cause to be done by virtue hereof.

(b) Corporation further grants this Limited Power of Attorney to Aaron Burton ("Pharmacist-In-Charge") to act as the true and lawful agent and attorney in-fact of Corporation, and to act in the name, place, and stead of Corporation, to execute applications for Forms 222 and to sign orders for Schedule II controlled substances, whether these orders be on Form 222 or electronic, in accordance with 21 U.S.C. § 828 and Part 1305 of Title 21 of the Code of Federal Regulations, as is necessary for the treatment of pharmacy patients. Corporation hereby ratifies and confirms all that said Pharmacist-In-Charge must lawfully do or cause to be done by virtue hereof.

(c) Corporation shall have the right, for the Limited Period described in Section 3 below, to operate under all of the Licenses and Registrations, until it is able to obtain all requisite licenses and registrations for itself.

2. Registrant recognizes that it remains legally responsible for Licenses and Registrations issued to it, during the period in which this Limited Power of Attorney is in effect. Therefore, Registrant grants this Limited Power of Attorney to Corporation based upon the following covenants and warranties of Corporation: (a) Corporation shall follow and abide by and comply with all federal and state laws governing the regulation of controlled substances, and the operation of the pharmacies, laboratories, blood banks and blood collection facilities set forth on Exhibit A hereto at all times while utilizing this Limited Power of Attorney and shall indemnify and hold Registrant harmless from and against any claims arising out of Corporation's failure to do so; and (b) Corporation, or its designee, shall make application for and pursue its own licenses

and registrations relating to controlled substances, and the operation of pharmacies, laboratories, blood banks and blood collection facilities that are required by law as soon as practicable.

3. This Limited Power of Attorney shall remain in effect for a period not to exceed one hundred twenty (120) days following the closing date of the Purchase Agreement (the "Limited Period").

4. Registrant may revoke this Limited Power of Attorney at any time by executing the Notice of Revocation, attached hereto at Exhibit B.

5. This Limited Power of Attorney may be executed in multiple counterparts, each and all of which shall be deemed an original and all of which together shall constitute one and the same instrument. A signature delivered by facsimile or PDF will be sufficient for all purposes among the parties hereto and shall be deemed to have the same legal effect as delivery of an original.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, Registrant and Corporation have executed this Limited Power of Attorney as of the _____ day of _____, 2016 to be effective as of 12:01 a.m. Eastern Time on the 1st day of October, 2016.

REGISTRANT:

WITNESS

THE WATERBURY HOSPITAL

_____

By: _____
Name: Darlene Stromstad
Title: President & Chief Executive Officer

WITNESS

CORPORATION:

_____

PROSPECT WATERBURY, INC.

By: _____
Name: Samuel S. Lee
Title: President

(*Limited Power of Attorney Signature Page – The Waterbury Hospital)*

I, _____, hereby affirm that I am the person named herein as attorney-in-fact pursuant to Section 1(b) of the Limited Power of Attorney and that the signature affixed hereto is my signature.

_____
Name:
Pharmacist-In-Charge

Witness: _____

Witness: _____

(*Limited Power of Attorney Signature Page – Pharmacist-In-Charge – The Waterbury Hospital)*

EXHIBIT A

Location	***License/Registration***	***License/Registration #***
The Waterbury Hospital	U.S. Drug Enforcement Agency Controlled Substance Registration	#AW2383153
The Waterbury Hospital	Controlled Substance Registration	#CSP-0004347-Hosp
See at right	Connecticut Laboratory Licenses	#HP-0255(Approved Public Laboratory) #DS-0536 (Thomaston) #07D0100126 (Main Lab License) #CL-0734 (Naugatuck) #HP-0255 (Waterbury Hospital Lab License)
See at right	Connecticut Blood Bank and Blood Collection Facility Registrations	#DS-1079 (Chase Outpatient Center) #DS-0043 (Grandview) #DS-0611 (Middlebury Edge) #DS-0672 (Southbury) #DS-0536 (Thomaston) #DS-0578 (Watertown) #BB-1008 (General Blood Banking Operations)
See at right	CMS Laboratory – CLIAs	#07D0950241 (Naugatuck Lab) #07D0100126 (Waterbury Hospital)

EXHIBIT B

The Limited Power of Attorney, executed on _____ ____, 2016, is hereby revoked by the undersigned, who is authorized to sign the current applications for the Licenses and Registrations. Written notice of this revocation has been given to the attorney-in-fact this same day.

By: _____
Name:
Title:

Witness: _____

Witness: _____

Exhibit C

Essential Clinical and Other Services

Buyer shall provide the following essential clinical and other services: (a) Emergency Department/Services (including trauma services), (b) General Medicine, (c) Behavioral Health Services, (d) Inpatient and Outpatient Surgery, (e) Radiology and Diagnostic Services, (f) Obstetrics and Gynecology (including those reproductive services currently provided at the Hospital), (g) Cardiology Services including Open Heart Services (subject to the receipt by Buyer of any and all required certificate of need approvals, licensure, registration, accreditation and certification necessary to provide such services in Connecticut), (h) Intensive Care Services, and (i) Neonatal Intensive Care Services (each, an "**Essential Service**"); *provided*, *however*, that if any of the following contingencies occurs with regard to any particular Essential Service, the Buyer may suspend, terminate, discontinue or materially and substantially modify, limit, or reduce (as applicable) the Essential Service:

(i) The medical staff of the facilities then owned or operated by the Buyer do not include qualified physicians necessary to support the provision of the Essential Service;

(ii) An Essential Service experiences a significant decrease in patient volumes for any reason not within the reasonable control of the Buyer, including technological obsolescence, changes in method, techniques or sites for delivery of the Essential Service, pharmaceutical advancements, failure of the Essential Service to qualify for reimbursement under Medicare (or any successor program) or a material portion of other payors, demographic and other market changes, or other competitive/marketplace factors; or

(iii) The actual or projected volume or clinical staffing for an Essential Service is or will be insufficient to achieve or maintain the level of quality for such Essential Service that is at least equal to, or better than, the level of quality at which the Essential Service is provided at any other general acute care community hospital in the region.

DISCLOSURE SCHEDULES

TO

ASSET PURCHASE AGREEMENT

by and between

GREATER WATERBURY HEALTH NETWORK, INC.

SELLER

and

PROSPECT CT MEDICAL FOUNDATION, INC.
PROSPECT WATERBURY, INC.
PROSPECT WATERBURY HOME HEALTH, INC.

BUYER

Dated as of September 27, 2016

These disclosure schedules have been arranged into separately titled sections corresponding to sections of the asset purchase agreement referenced above (the "Agreement"); provided, however, that any information included in these disclosure schedules shall be deemed to be disclosed and incorporated by reference into any other section or subsection of these disclosure schedules to the extent that such disclosure would clearly be responsive to such other section of the Agreement. Capitalized terms used in these disclosure schedules and not otherwise defined herein have the meaning given to them in the Agreement. The inclusion of any item in these disclosure schedules is not intended to imply that the items so included, or other items, are required to be disclosed (including, without limitation, whether such items are required to be disclosed as material or threatened). The information contained in these disclosure schedules is disclosed solely for purposes of the Agreement, and no information contained herein or therein will be deemed to be an admission by any party to any third party of any matter whatsoever (including, without limitation, any violation of law or breach of contract).

Schedules to Asset Purchase Agreement

SCHEDULE	
Schedule 1.01(4)	Accounts Receivable
Schedule 1.02(i)	Persons with □Seller□s □nowledge□
Schedule 2.01(a)	Owned Real Property
Schedule 2.01(b)	Leased Real Property
Schedule 2.01(c)(i)	Description of Personal Property
Schedule 2.01(c)(ii)	Leased Personal Property
Schedule 2.01(f)	Assumed Contracts
Schedule 2.01(g)	Permits
Schedule 2.01(h)	Intellectual Properties
Schedule 2.01(m)	Prepaids
Schedule 2.01(y)	CHA Claims
Schedule 2.02(n)	Excluded Third Party Claims
Schedule 2.02(□)	Excluded Contracts
Schedule 2.02(t)	Other Excluded Assets
Schedule 2.03(d)	Capital Lease Obligations
Schedule 2.03(g)	Assumed Employee Benefit Plans
Schedule 2.04	Additional Excluded Claims and Obligations
Schedule 2.05(a)(vii)	Additional Liabilities Deducted from Purchase Price
Schedule 3.02(c)	Exceptions to Absence of Conflicts
Schedule 3.04	Investments and Third Party Rights
Schedule 3.05(a)	Legal Compliance
Schedule 3.05(b)	Corporate Integrity Agreements, Investigations and Complaints
Schedule 3.06	Financial Statements and Undisclosed Liabilities
Schedule 3.07	Recent Activities
Schedule 3.09	E□uipment Depreciation Schedule
Schedule 3.10	Title to Assets
Schedule 3.11(a)	Permitted Encumbrances
Schedule 3.11(b)	Real Property Disclosures
Schedule 3.12	Environmental Claims
Schedule 3.13	Intellectual Properties and Information Systems
Schedule 3.14	Insurance
Schedule 3.15	Permits Not in Good Standing
Schedule 3.16(a)	Government Payment Programs and Accreditation
Schedule 3.16(b)	Cost Reports
Schedule 3.17	Contracts Related to the Hospital Businesses
Schedule 3.18	Consent, Assignment and Prohibitions on Competition
Schedule 3.19	Transactions with Affiliates
Schedule 3.20(a)	Labor Disputes
Schedule 3.20(b)	Collective Bargaining Agreements
Schedule 3.20(c)	Claims Involving Legal Re□uirements of Employment
Schedule 3.20(d)	Recently Terminated Employees
Schedule 3.20(f)	Pending Immigration Proceedings

Schedule 3.21(a)	Employee Benefit Plans
Schedule 3.21(c)	Employee Benefit Plan Compliance and Issues
Schedule 3.22	Proceedings and Claims
Schedule 3.24	Material Medical Staff Disputes
Schedule 3.25	Restricted Assets
Schedule 3.28	Joint Ventures and Converted Ventures
Schedule 3.29	Material Tangible Assets
Schedule 6.03	Exceptions to Non-Compete
Schedule 6.09	Charity Care and Community Obligations
Schedule 8.02(e)	Grants
Schedule 8.06	Consents to Assignment of Assumed Contracts

SCHEDULE 1.01(4)

ACCOUNTS RECEIVABLE

[REDACTED PER CONN. GEN. STAT. 1-210(b)(5)]

SCHEDULE 1.02(i)

PERSONS WITH "SELLER'S KNOWLEDGE"

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.01(a)

OWNED REAL PROPERTY

For The Waterbury Hospital:

A. Waterbury Hospital Main Campus – 64 Robbins Street, 134 Grandview Avenue, 140 Grandview Avenue, 170 Grandview Avenue, Waterbury

Those certain pieces and parcels of land, with the buildings and improvements thereon comprising the Main Campus, located at 64 Robbins Street and 170 Grandview Avenue, and certain land only, subject to leases of record, with street addresses of 134 Grandview Avenue and 140 Grandview Avenue:

FIRST PARCEL: A certain tract of land with the Hospital and other buildings and improvements thereon standing, bounded:

NORTHERLY	by land of The Waterbury Hospital, formerly of Loren Carter, being the land hereafter described;
EASTERLY	by Watertown Avenue;
SOUTHERLY	by Robbins Street; and
WESTERLY	by Grandview Avenue.

Containing twenty-four (24) acres, more or less.

Being the same premises conveyed to The Waterbury Hospital by Charles L. and Walter W. Holmes by deed dated February 18, 1907, recorded February 25, 1907, in Vol. 202, Page 553 of the Waterbury Land Records, excepting a portion conveyed by The Waterbury Hospital to the City of Waterbury for highway purposes by deed dated June 20, 1940, and recorded August 21, 1940, in Vol. 506, Page 191 of said land records.

SECOND PARCEL: Consisting of Four Pieces, being shown on a Map entitled "Map of Woodside, Waterbury, Conn. A.J. Patton, Surveyor", on file in the Waterbury Town Clerk's Office in Map Book 1, Page 25, and containing eighteen (18) acres, more or less, to wit:

First Piece: Lots Nos. 38, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, the southerly 40 feet of Lot 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89 and 90, as shown on said Map.

Second Piece: The southerly 145 feet of Lots Nos. 39 and 40, as shown on said Map.

Third Piece: Being the Homestead as shown on said Map, bounded

NORTHERLY	135 feet on Hale Street, so-called;

EASTERLY	425.74 feet in curved line on Winthrop Terrace, so-called;
SOUTHERLY	143.46 feet on Carter Avenue, so-called; and
WESTERLY	341.76 feet on Lots Nos. 61 and 53, as shown on said Map.

Fourth Piece: Bounded:

NORTHERLY	running to a point at the junction of Carter Avenue, so-called, and Watertown Avenue;
EASTERLY	on Watertown Avenue;
SOUTHERLY	on land of The Waterbury Hospital;
WESTERLY	on Lot No. 90 as shown on said Map; and
NORTHWESTERLY and again WESTERLY on Carter Avenue, so-called.	

Included in the Second Parcel are the streets and portions of streets, all as shown on the "Map of Woodside" on file in the Waterbury Town Clerk's Office in Map Book 1, Page 1, as described and conveyed in the Executor's Deed from L. Russell Carter, Executor of the Estate of Loren R. Carter, to The Waterbury Hospital, dated November 13, 1952, recorded in Volume 667, page 40 of the Waterbury Land Records: Hale Street, Winthrop Terrace and Carter Avenue, subject to possible passway rights.

Being the same land conveyed to The Waterbury Hospital by L. Russell Carter, Executor under the Will of Loren R. Carter by deed dated and recorded November 13, 1952, in Vol. 667, Page 49 of the Waterbury Land Records.

Together with any and all rights under easement from John W. Potter to Loren R. Carter dated May 14, 1917 recorded in Vol. 282, Page 177 of the Waterbury Land Records.

Excluding from said Parcels the properties described in a Certificate of Taking by the State of Connecticut, dated March 21, 1963 and recorded in Volume 842, Page 30 and in a Quit Claim Deed from Waterbury Hospital to the State of Connecticut dated June 7, 1963 recorded in Volume 847, Page 397, each of the Waterbury Land Records.

Together with the benefits of a certain Agreement by the City of Waterbury with Loren R. Carter dated December 10, 1907, recorded November 4, 1931 in Volume 450, Page 625 of the Waterbury Land Records. While this is appurtenant, if still valid, the location of the steps and wall is on property of The Waterbury Hospital.

B. Property at 36 Grandview Avenue, Waterbury

All that certain piece or parcel of land, with all the improvements thereon, known as "36 Grandview Avenue, situated in the Town of Waterbury, County of New Haven and State of Connecticut, bounded and described as follows:

A certain piece or parcel of land situated on the easterly side of Grandview Avenue, and being the northerly one half of Lot "3 and Lot "4 on PLAN OF LAND OF SAMUEL ROOT, made by the A. J. Patton company, February 1910, bounded and described as follows:

NORTHERLY - 100 feet on Lots 5, 6 and 7;

EASTERLY - 60 feet on Lots 7 and 10;

SOUTHERLY - 100 feet on southerly one half of Lot 3;

WESTERLY - 60 feet on Grandview Avenue.

Being the same premises conveyed to The Waterbury Hospital by Greater Waterbury Health Network, Inc. by Quit-Claim Deed dated December 30, 1997 and recorded in Volume 3571 at Page 135 of the Waterbury Land Records.

For Greater Waterbury Management Resources, Inc.

C. 305 Church Street Condominium, Unit 7, 305 Church Street, Naugatuck

That certain real property located in the Town of Naugatuck, County of New Haven and State of Connecticut, known as Unit 7 of 305 Church Street Condominium, together with the interest in the Common Elements appurtenant thereto, said Unit and Common Elements being more specifically designated and described in the original Declaration entitled Declaration of 305 Church Street Condominium declared by Professional Park dated January 1989 recorded on January 13, 1989 in Volume 326, Page 613 of the Naugatuck Land Records, as the same may have been amended and or supplemented.

For VNA Health at Home, Inc.:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For Alliance Medical Group, Inc.:

None.

For Greater Waterbury Health Network, Inc.:

None.

SCHEDULE 2.01(b)

LEASED REAL PROPERTY

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.01(c)(i)

DESCRIPTION OF PERSONAL PROPERTY

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.01(c)(ii)

LEASED PERSONAL PROPERTY

[REDACTED PER CONN. GEN. STAT. 1-210(b)(5)]

SCHEDULE 2.01(f)

ASSUMED CONTRACTS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.01(g)

PERMITS

Permits held by The Waterbury Hospital, to the extent legally assignable:

Type of Permit Registration	Issuing Authority	Permit Registration No.	Expiration Date
ADAC Laboratories FORTE 2003 FOR Planar, SPECT and Nuclear Cardiology	American College of Radiology	None	7 14 2017
Air Permit to Operate- Cleaver Brooks Boiler No 2	CT DEEP Bureau of Air Management	OP 192-0105	None
Air Permit to Operate- Cleaver Brooks Boiler No 3	CT DEEP Bureau of Air Management	CP OP 192-0115	None
Air Permit-By-Rule ohler Emergency Generator 1	CT DEEP Bureau of Air Management	None	None
Air Permit-By-Rule ohler Emergency Generator 2	CT DEEP Bureau of Air Management	None	None
Air Permit-By-Rule ohler Emergency Generator 3	CT DEEP Bureau of Air Management	None	None
Amended Materials License to include Ehsan Ansari, MD	US Nuclear Regulatory Commission (Region 1)	06-02406-01	5-May-16
Approved Public Laboratory	CT Department of Health	HP 0255	31-Dec-17
Blood Draw Station License - Chase Outpatient Center	State of Connecticut Department of Health	DS-1079	None
Blood Draw Station License Grandview	State of Connecticut Department of Health	DS-0043	None
Blood Draw Station License - Middlebury Edge	State of Connecticut Department of Health	DS 0611	None
Blood Draw Station License - Southbury	State of Connecticut Department of Health	DS 0672	None
Blood Draw Station License - Thomaston	State of Connecticut Department of Health	DS 0536	None
Blood Draw Station License - Watertown	State of Connecticut Department of Health	DS 0578	None

Type of Permit Registration	Issuing Authority	Permit Registration No.	Expiration Date
Boiler Operating Certificates	CT Div of Construction Svcs. Bureau of Boilers	048936, 048883	9-Sep-16
Certificate of Self - Insurance and ability to pay compensation directly to injured employees	State of Connecticut Workers Compensation Commission	None	6 1 2015 Expires 31 May-16 Extended to 31-Sep-16
Certificate of Use & Occupancy Surgery	City of Waterbury, CT	PR20110003496	Completed 1 10 2013
Clinical Laboratory - Thomaston	CT Department of Health	DS-0536	14-Oct-15
Clinical Laboratory (Main Lab License)	CT Department of Health	07D0100126	2 28 17 expires 2 28 2017
Clinical Laboratory (Naugatuck)	CT Department of Health	CL 0734	14-Sep-17
Clinical Laboratory Improvement Amendments Certificate of Accreditation - Naugatuck Lab	Centers for Medicare & Medicaid Services	07D0950241	Effective 9 15 2015 - Expires 9 14 2017
Clinical Laboratory Improvement Amendments Certificate of Accreditation - Waterbury Hospital	Centers for Medicare & Medicaid Services	07D0100126	Effective 02 28 2015 - Expires 02 27 2017
Clinical Laboratory License, Naugatuck, CT	State of Connecitcut Department of Public Health	CL 0734	31-Dec-17
Compliance Notification	CT Dept of Public Safety, Office of State Fire Marshal	None	1-Sep-16
Connecticut Sales and Use Tax Permit	State of Connecticut Department of Revenue Services	License 1219602 Registration 6653448-001	June 1, 2006 - March 31, 2021
Controlled Substance Registration	United States Dept of Justice Drug Enforcement Administration	AW2383153	Issued 4-2-15
Controlled Substance Registration	State of Connecticut Department of Consumer Protection	CSP-0004347-Hosp	Effective 3 1 15 - Expires 2 28 2017

Type of Permit Registration	Issuing Authority	Permit Registration No.	Expiration Date
Diagnostic and Therapeutic X-Ray Device Registration	CT DEEP Bureau of Air Management	3161	30-Apr-18
Diagnostic and Therapeutic X-Ray Devices	CT DEEP Bureau of Air Mgmt Radiation Division	2212306	30-Apr-18
FDA Blood Bank Registration	Dept of Health & Human Services US Food and Drug Administration - New England Office	FEI: 1271998 CFN: 1271998	Validated: 11-24-2015
Fire Extinguisher Inspection	Fire Control Service, Inc.	Issued 20-May-16	None
Food Service Permit - Granted to Morrison Food & Nutrition	City of Waterbury, CT Department of Health	385	2-1-16 - 1-31-17
Food Service Permit - Granted to Morrison Food & Nutrition	City of Waterbury Department of Health	385	2-1-2016 Expires 31-Jan-17
GE AMX 4 Port 4 SN:1483	Thomas J. LaRocca, LORAD	PASS (8-Apr-16) (Collimator Field Size Indicators Missing Service repair required)	None
GE Radiation Room 10 Inspection	Bio-Med Associates	PASS	3-Mar-16
General Blood Banking Operations	CT Department of Health	BB 1008	31-Dec-17
General Permit for the Discharge of Minor Non-Contact Cooling and Heat Pump Water	CT DEEP Bureau of Materials Management & Compliance Assurance	None	29-Mar-17
General Permit for the Discharge of Minor Photographic Processing Wastewater	CT DEEP Bureau of Materials Management & Compliance Assurance	GPH000127	21-Jun-20
General Permit for the Discharge of Wastewater Associated with Food Service Establishments	CT DEEP Bureau of Materials Management & Compliance Assurance	None	4-Oct-25

Type of Permit Registration	Issuing Authority	Permit Registration No.	Expiration Date
General Permit for the Discharge of Water Treatment Wastewater	CT DEEP Bureau of Materials Management & Compliance Assurance	GWT000137	29-Mar-17
General Permit to Limit Potential to Emit (GPLPE)	CT DEEP Bureau of Air Management	192-0189-GPLPE	8-Nov-20
Helipad Log *demonstrating usage does not meet requirement for Permit*	State of Connecticut, Department of Transportation		
Hospital License	CT Department of Health	0060	30-Sep-17
Industrial Alcohol User Permit	US Departement of the Treasury Alcohol and Tobacco Tax and Trade Bureau	TF-CT-299	Amended 4 24 2009
Materials License	US Nuclear Regulatory Commission (Region 1)	06-02406-01	31-Mar-26
Medical Physicists Breast Biopsy Quality Control Test Summary	Thomas J. LaRocca, LORAD	PASS (31-Mar-16)	None
Medical Physicists Mammography Quality Control Test Summary	Thomas J. LaRocca, LORAD	PASS (13-Oct-15)	None
Non-RCRA Ha ardous Biomedical Waste (Large Quantity Generator)	CT DEEP	2827	June 30,2016
North Wing Passenger (right) 8 Otis D74864	CT Div of Construction Svcs - Bureau of Elevators	151-0113	1-Feb-18
North Wing Passenger (right) 9 Otis D74865	CT Div of Construction Svcs - Bureau of Elevators	151-0114	1-Feb-18
Passenger Grandview 7 Otis 244611	CT Div of Construction Svcs - Bureau of Elevators	151-0434	1-Feb-18
Passenger Main Center (left) C-2 Otis 242432	CT Div of Construction Svcs - Bureau of Elevators	151-0432	1-Feb-18

Type of Permit Registration	Issuing Authority	Permit Registration No.	Expiration Date
Passenger Main Center (right) C-1 Otis 242431	CT Div of Construction Svcs - Bureau of Elevators	151-0431	1-Feb-18
Permit for Fuel Burning E uipment (Generator 1)	CT DEEP Bureau of Air Mgmt	0135	None
Permit for Fuel Burning E uipment (Generator 2)	CT DEEP Bureau of Air Mgmt	0136	None
Permit for Fuel Burning E uipment (Generator 3)	CT DEEP Bureau of Air Mgmt	0137	None
Pomeroy Dumbwaiter - Clean PE-1 Otis C01848	CT Div of Construction Svcs - Bureau of Elevators	151-0369	1-Feb-18
Pomeroy Dumbwaiter - Dirty PE-2 Otis C01847	CT Div of Construction Svcs - Bureau of Elevators	151-0370	1-Feb-18
Pomeroy Passenger PE-1 Otis C01840	CT Div of Construction Svcs - Bureau of Elevators	151-0336	1-Feb-18
Pomeroy Passenger PE-2 Otis C01841	CT Div of Construction Svcs - Bureau of Elevators	151-0337	1-Feb-18
Pomeroy Passenger PE-3 Otis C01842	CT Div of Construction Svcs - Bureau of Elevators	151-0338	1-Feb-18
Pomeroy Service Elevator SE-5 Otis C01843	CT Div of Construction Svcs - Bureau of Elevators	151-0381	1-Feb-18
Pomeroy Service Elevator SE-6 Otis C01844	CT Div of Construction Svcs - Bureau of Elevators	151-0382	1-Feb-18
Pomeroy Service Elevator SE-7 Otis C01845	CT Div of Construction Svcs - Bureau of Elevators	151-0383	1-Feb-18
Radio Station License (Walkie Talkies and Life Star ((Helicopter))	Federal Communication Commission	Call Sign: WQUP781 Fre uency Coordination PC20142060022	Effective 09 04 2014 Expires 09 04 2024
Radioactive Material & Industrial X-Ray Devices	CT DEEP Bureau of Air Mgmt Radiation Division	2198252	31-Dec-16

Type of Permit Registration	Issuing Authority	Permit Registration No.	Expiration Date
Radioactive Material and Industrial X-Ray Device Registration	CT DEEP Bureau of Air Management	0391	31-Dec-16
RCRA Subtitle C Non-RCRA Ha ardus Biomedical Waste	US Environmental Protection Agency	*See:* Ha ardous Waste	24-Feb-16
Siemans Rad Room 9 performance report	Thomas J. LaRocca, LORAD	PASS (3-Mar-16)	None
Siemans X-Ray ARCADIS Orbic C Arm	Thomas J. LaRocca, LORAD	PASS (8-Apr-16)	None
Siemans X-Ray Room 7 - Presitge VH R&F Unit	Thomas J. LaRocca, LORAD	PASS (8-Apr-16)	None
Siemans X-Ray Room 8 - Tube 1	Thomas J. LaRocca, LORAD	PASS (8-Apr-16)	None
Siemans X-Ray Room 8 - Tube 2	Thomas J. LaRocca, LORAD	PASS (8-Apr-16)	None
GE X-Ray Room 10 - Advantx Room 10	Thomas J. LaRocca, LORAD	PASS (3-Mar-16)	None
Toshiba A uilion	Thomas J. LaRocca, LORAD	PASS (30-Aug-16)	None
Tax Exempt Permit	State of Connecticut Department of Revenue Services	E-00524 (8 1 1957)	None
Water Treatment - Wastewater	CT Department of Environmental Protection	GWT 000137	29-Mar-17
Waterbury Hospital Lab License	State of Connecitcut Department of Public Health	HP 0255	17-Sep-17
West Wing Passenger (left) 4 Otis C73880	CT Div of Construction Svcs - Bureau of Elevators	151-0416	1-Feb-18
West Wing Passenger (right) 2 Otis C73882	CT Div of Construction Svcs - Bureau of Elevators	151-0417	1-Feb-18

WATERBURY HOSPITAL ACCREDITATIONS		
ACGME	Internal Medicine Resident Program in connection with Yale New Haven Medical Center	Effective: 1 15 2016
ACGME	Waterbury Hospital Surgical Department	Effective: 6 25 15

American College of Radiology	Nuclear Medicine Services, Ultrasound, Mammographic Imaging Services, Computed Tomography Services	Term: July 15, 2014 - July 14, 2017
American College of Radiology	ADAC Laboratories FORTE 2003 for Planar, SPECT, Nuclear Cardiology	Term: July 15, 2014 to July 14, 2017
American College of Radiology	ADAC Laboratories FORTE 2000 for Planar, SPECT	Term: July 14, 2014 to July 14, 2017
American College of Radiology	Gynecological, General, Vascular	Term: July 11, 2014 to August 29, 2017
American College of Radiology	Gynecological, General, Vascular	Term: April 14, 2014 to April 19, 2017
American College of Radiology	Toshiba A□uilion 32 2006 for Head□Neck, Chest and Abdomen□	Term: August 26, 2013 to August 26, 2016
American College of Radiology	Toshiba A□uilion Prime 80 2-15 for Head□Neck, Chest and Abdomen□	Term: Februrary 29, 2016 to December 07, 2018
American College of Radiology	Toshiba AQ64 CFX 6B 2006 for Head□Neck, Chest and Abdomen□	Term: December 7, 2015 through December 07, 2018
American College of Radiology (Mammography)	Lorad Medical Systems, Inc, Selinia 2008	Term: February 17, 2016 through October 02, 2018
American College of Surgeons Committee on Trauma	Verification as a Level II Trauma Center	Expires January 9, 2018
Centers for Medicare and Medicaid Services	Certification by Clinical Laboratory Improvement Amendments	Hospital Lab - Term: February 28, 2015 - February 27, 2017
Centers for Medicare and Medicaid Services	Certification by Clinical Laboratory Improvement Amendments	Naugatuck Lab - Term: September 15, 2015 - September 14, 2017
College of American Pathologists	Naugatuck Laboratory Accreditation CAP □1192702 AU ID:1194131	Expires: April 29, 2017
College of American Pathologists	Waterbury Hospital Laboratory Accreditation CAP □1192701 AU ID:1177236	Expires: April 29, 2017
Commission on Cancer	3-year Accreditation with Commendation	Term: September 5, 2014 to September 2017
Connecticut State Medical Society	Letter advising Hospital it is in full compliance (May 9, 2016)	None

National Accreditation for Breast Centers	3-year Full Accreditation	Extended by letter to Sept 2016
The Joint Commission	Full Accreditation	Effective: 6-10-2016
The Joint Commission	Behavioral Health Accreditation	Effective: 6-10-2016

Permits held by Alliance Medical Group, Inc., to the extent legally assignable:

Group NPI: 1316273071
Medicare PTAN: D100010277
Group Taxonomy: 193200000X

Permits held by VNA Health at Home, Inc., to the extent legally assignable:

Centers for Medicare and Medicaid Services, Clinical Laboratory Improvements Amendments, Certificate of Waiver, Expires 4-12-2018

State of Connecticut, Department of Public Health, Home Health Care Agency License No. C895710, Expires 6-30-2018

Visiting Nurse Association of New England, Managed Care Contracting, Expires 6-30-2017

Visiting Nurse Association of America, National Homecare Association, Expires 12-31-2016

Permits held by Cardiology Associates of Greater Waterbury, LLC, to the extent legally assignable:

Centers for Medicare and Medicaid Services, Clinical Laboratory Improvements Amendments, Certificate of Waiver, expires 2-6-2017

Certificate of Accreditation from Intersocietal Accreditation Commission Nuclear-PET ICANL issued to Waterbury Hospital Cardiac Diagnostic Center for 455 Chase Parkway, Waterbury, Connecticut for nuclear cardiology, valid through October 21, 2016

Radioactive Material Industrial X-Ray Devices Permit issued by the State of Connecticut Department of Energy and Environmental Protection to The Waterbury Hospital, 455 Chase Parkway, Waterbury, Connecticut, valid through December 31, 2016

Permits held by Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 2.01(h)

INTELLECTUAL PROPERTIES

For The Waterbury Hospital and Greater Waterbury Health Network, Inc.:

Logos:

Website domains owned registered:

All Domains (12)

Domain Name	Expires	Status
BEWELLCENTER.COM	7/9/2017	Active
BEWELLCENTER.ORG	5/12/2017	Active
GREATERWATERBURYIMAGINGCENTER-CHAN...		DNS Only (Hosting)
GWHN.COM	5/22/2017	Active
GWHN.ORG	10/19/2017	Active
INCORPORATORS.ORG	9/23/2017	Active
WATERBURYHOSPITAL.COM	12/13/2017	Active
WATERBURYHOSPITAL.ORG	6/13/2017	Active
WATERBURYHOSPITALPHYSICIANS.COM	12/8/2017	Active
WATERBURYHOSPITALPHYSICIANS.ORG	12/8/2017	Active
WATERBURYSURGERY.COM	10/16/2017	Active
WATERBURYSURGERY.ORG	9/27/2017	Active

Also, WTBYHOSP.ORG, expires: 8 6 2019, status: active

NOTE: the only active domain with content is Waterburyhospital.org

Other social media sites:

Facebook: https: www.facebook.com WaterburyHospital ref aymt_homepage_panel
LinkedIn:
https: www.linkedin.com company 35536 trk vsrp_companies_cluster_name&trkInfo VSRPsearchId 3A350015061466607919635 2CVSRPtargetId 3A35536 2CVSRPcmpt 3Acompanies_cluster
Twitter: Waterburyhosp
Instagram: Waterburyhospital

Trade names: Waterbury Hospital Health Center; GWHN, Greater Waterbury Health Network

For Alliance Medical Group, Inc.:

Logo:

Domain Name and website: www.alliancemedicalgroup.com

Date of Original Registration: January 10, 2006

Registration Expiration Date: January 10, 2019

Facebook: https://www.facebook.com/Alliance-Medical-Group-466414466740123/

Trade names: Alliance Medical Group, AMG

For Cardiology Associates of Greater Waterbury, LLC:

Logo:

Domain Name and website: CAWTBY.com

Date of Original Registration: November 26, 1998

Registration Expiration Date: November 25, 2017

Facebook: https://www.facebook.com/Cardiology-Associates-of-Waterbury-182684038429284/

Trade name: Cardiology Associates of Greater Waterbury, CAGW

For VNA Health at Home, Inc.:

Logo:

Domain Name: vnahealthathome.org

Registration expires: June 20, 2017

Facebook: https: www.facebook.com vnahealthathome hc_ref PAGES_TIMELINE&fref nf

Trade name: VNA Health at Home

Copyrightable Works (all entities):

None.

Live Registered Trademarks or Pending Trademark Applications (all entities):

None.

SCHEDULE 2.01(m)

PREPAIDS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.01(y)

CHA CLAIMS

Those claims being organi□ed and supported by the Connecticut Hospital Association which are currently Applications to the Departments of Social Services and Revenue Services, seeking declaratory rulings from the agencies on whether the so-called □provider tax□ on hospitals is constitutional, including, without limitation, such other or related claims in connection with DSH payments and taxes previously paid by Seller in connection with psychiatric and lab claims.

SCHEDULE 2.02(n)

EXCLUDED THIRD PARTY CLAIMS

None.

SCHEDULE 2.02(q)

EXCLUDED CONTRACTS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.02(t)

OTHER EXCLUDED ASSETS

[REDACTED PER CONN. GEN. STAT. 1-210(b)(5)]

SCHEDULE 2.03(d)

CAPITAL LEASE OBLIGATIONS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.03(g)

ASSUMED EMPLOYEE BENEFIT PLANS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 2.04

EXCLUDED LIABILITIES

For Greater Waterbury Health Network, Inc.:

None.

For Waterbury Hospital:

None.

For Alliance Medical Group:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For VNA Health at Home, Inc.:

None.

For Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 2.05(a)(vii)

ADDITIONAL LIABILITIES DEDUCTED FROM PURCHASE PRICE

For Greater Waterbury Health Network, Inc.:

None.

For Waterbury Hospital:

None.

For Alliance Medical Group:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For VNA Health at Home, Inc.:

None.

For Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 3.02(c)

EXCEPTIONS TO ABSENCE OF CONFLICTS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.04

INVESTMENTS AND THIRD PARTY RIGHTS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.05(a)

LEGAL COMPLIANCE

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.05(b)

CORPORATE INTEGRITY AGREEMENTS, INVESTIGATIONS AND COMPLAINTS

[REDACTED PER CONN. GEN. STAT. 1-210(b)(5)]

SCHEDULE 3.06

FINANCIAL STATEMENTS AND UNDISCLOSED LIABILITIES

Greater Waterbury Health Network, Inc. and Subsidiaries Consolidated Financial Statements, September 30, 2015 and 2014 (attached hereto)

Greater Waterbury Health Network, Inc. and Subsidiaries Consolidated Financial Statements, September 30, 2013 and 2012 (attached hereto)

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

GREATER WATERBURY HEALTH NETWORK, INC.
AND SUBSIDIARIES

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MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT

Board of Directors
Greater Waterbury Health Network, Inc.

We have audited the accompanying consolidated financial statements of Greater Waterbury Health Network, Inc. and Subsidiaries, which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards re□uire that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors□ judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity□s preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity□s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting polices used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Greater Waterbury Health Network, Inc. and Subsidiaries as of September 30, 2015 and 2014, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Marcum LLP

Hartford, CT
January 18, 2016

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

SEPTEMBER 30, 2015 AND 2014

	2015	2014
Assets		
Current Assets		
Cash and cash equivalents	$ 22,023,992	$ 34,127,272
Restricted cash	1,350,000	675,000
Short-term investments	1,527,528	1,420,733
Patient accounts receivable, less allowance ($5,232,000 in 2015 and $9,288,000 in 2014)	32,315,680	31,329,622
Grants and other receivables	3,837,291	3,843,762
Inventories	3,461,115	3,922,673
Prepaid insurance and other expenses	2,060,247	1,967,241
Due from affiliates	189,380	190,880
Total Current Assets	66,765,233	77,477,183
Other Assets		
Under bond indenture agreements	31,682	32,613
Funds held in trust by others	43,411,397	46,117,761
Goodwill	1,813,567	1,813,567
CHEFA obligations issue expense, less amortization	204,696	243,686
Long-term investments	25,903,153	26,937,851
Board-designated endowment funds	--	3,315,500
Other investments	80,000	80,000
Loans and other receivables	293,725	231,105
Accrued interest and dividends receivable	18,169	52
Total Other Assets	71,724,707	78,739,522
Property, plant and equipment:		
Land	287,549	287,549
Buildings and improvements	97,552,740	97,400,827
Furniture, fixtures and equipment	194,547,864	188,855,009
Construction in progress	13,934	--
Less accumulated depreciation	(256,109,338)	(248,520,576)
Total Property, Plant and Equipment	36,292,749	38,022,809
Total Assets	$ 174,814,371	$ 194,272,127

The accompanying notes are an integral part of these consolidated financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS (CONTINUED)

SEPTEMBER 30, 2015 AND 2014

	2015	2014
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	□ 32,196,071	□ 33,650,793
Due to third-party reimbursement agencies	7,729,230	4,444,304
Current portion of CHEFA obligations	576,408	548,776
Current portion of notes payable and capital lease obligations	1,455,894	461,705
Total Current Liabilities	41,957,603	39,105,578
CHEFA Obligations - less current portion	24,483,336	25,059,744
Notes Payable and Capital Lease Obligations - less current portion	3,647,977	438,984
Other Noncurrent Liabilities	26,049,588	25,354,977
Net Assets		
Unrestricted	21,583,554	43,957,226
Temporarily restricted	8,220,369	8,729,527
Permanently restricted	46,203,433	48,909,797
Total Net Assets Excluding Noncontrolling Interests	76,007,356	101,596,550
Noncontrolling Interests	2,668,511	2,716,294
Total Net Assets	78,675,867	104,312,844
Total Liabilities and Net Assets	□ 174,814,371	□ 194,272,127

The accompanying notes are an integral part of these consolidated financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

FOR THE YEARS ENDED SEPTEMBER 30, 2015 AND 2014

	2015	2014
Revenues		
Net patient service revenues	$ 238,149,648	$ 253,394,006
Provision for bad debts	(4,483,187)	(4,454,817)
Net patient service revenues less provision for bad debts	233,666,461	248,939,189
Investment related income	1,876,016	1,706,241
Other operating revenues	4,620,874	4,332,689
Services, sales and rental income	1,766,102	1,657,959
Unrestricted gifts and bequests	669,579	1,249,261
Net assets released from restrictions	5,014,429	5,542,491
Total Revenues	247,613,461	263,427,830
Expenses		
Salaries, wages and benefits	154,106,643	151,760,190
Supplies, utilities and other	104,740,692	107,222,243
Depreciation	7,670,258	7,991,436
Interest and amortization	1,535,311	1,476,326
Total Expenses	268,052,904	268,450,195
Deficiency of Revenues over Expenses Before Net Unrealized (Losses) Gains on Investments	(20,439,443)	(5,022,365)
Changes in Net Unrealized (Losses) Gains on Investments	(1,197,928)	294,354
Deficiency of Revenues Over Expenses	(21,637,371)	(4,728,011)
Less Excess of Revenues over Expenses Attributable to Noncontrolling Interests	(750,533)	(926,677)
Deficiency of Revenues Over Expenses Attributable to Controlling Interest	(22,387,904)	(5,654,688)

The accompanying notes are an integral part of these consolidated financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2015 AND 2014

	2015	2014
Unrestricted Net Assets, Controlling Interest		
Deficiency of revenues over expenses	$ (22,387,904)	$ (5,654,688)
Net assets released from restrictions used for purchase of property and equipment	95,170	13,360
Interest rate swap adjustment	(338,948)	217,110
Pension liability adjustments	258,010	(841,605)
Decrease in Unrestricted Net Assets, Controlling Interest	(22,373,672)	(6,265,823)
Unrestricted Net Assets, Noncontrolling Interest		
Excess of revenues over expenses	750,533	926,677
Distributions	(798,316)	(924,889)
(Decrease) Increase in Unrestricted Net Assets, Noncontrolling Interest	(47,783)	1,788
Temporarily Restricted Net Assets		
Gifts and bequests	447,582	453,516
Income from investments	704,133	447,776
Net realized and unrealized (losses) gains on investments	(561,598)	604,989
Grants	4,010,322	4,369,303
Net assets released from restrictions	(5,109,597)	(5,555,851)
(Decrease) Increase in Temporarily Restricted Net Assets	(509,158)	319,733
Permanently Restricted Net Assets		
(Decrease) increase in fair value of funds held in trust by others	(2,706,364)	1,157,722
(Decrease) Increase in Permanently Restricted Net Assets	(2,706,364)	1,157,722
Decrease in Net Assets	(25,636,977)	(4,786,580)
Net Assets - Beginning	104,312,844	109,099,424
Net Assets - End	$ 78,675,867	$ 104,312,844

The accompanying notes are an integral part of these consolidated financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED SEPTEMBER 30, 2015 AND 2014

	2015	2014
Cash Flows from Operating Activities and Nonoperating Revenues		
Decrease in net assets	$ (25,636,977)	$ (4,786,580)
Adjustments to reconcile decrease in net assets to net cash (used in) provided by operating activities and nonoperating revenues:		
Provision for bad debts	4,483,187	4,454,817
Depreciation and amortization	7,709,248	8,030,426
Pension liability adjustments	(258,010)	841,605
Distributions to noncontrolling interests	798,316	924,889
Net realized and unrealized gains and change in fair value of funds held in trust by others	4,659,739	(2,378,554)
Restricted gifts, bequests and income from investments	(1,153,115)	(901,292)
Change in market value of interest rate swap	338,948	(217,110)
	(9,058,664)	5,968,201
Change in operating working capital, other than cash and cash equivalents and short-term investments:		
Patient accounts receivable, net	(5,469,245)	(5,826,686)
Grants and other receivables	6,471	(141,238)
Inventories	461,558	(335,852)
Prepaid insurance and other expenses	(93,006)	(364,145)
Accounts payable and accrued expenses	(1,454,722)	4,255,075
Due to third-party reimbursement agencies	3,284,926	1,301,118
Other noncurrent liabilities	613,673	2,916,975
	(2,650,345)	1,805,247
Net Cash (Used in) Provided by Operating Activities and Nonoperating Revenues	(11,709,009)	7,773,448

The accompanying notes are an integral part of these consolidated financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2015 AND 2014

	2015	2014
Cash Flows from Investing Activities		
(Increase) decrease in restricted cash	□ (675,000)	□ 3,844,908
Other assets	(62,620)	128,270
Additions to property, plant and e□uipment	(1,099,291)	(1,383,309)
Purchases of investments	(69,789,842)	(37,598,422)
Sales of investments	72,062,684	36,853,989
Net Cash Provided by Investing Activities	435,931	1,845,436
Cash Flows from Financing Activities		
Restricted gifts, be□uests and income from investments	1,153,115	901,292
Cash received from (paid to) affiliates	1,500	(1,501)
Distributions to noncontrolling interests	(798,316)	(924,889)
Net proceeds from issuance of debt	--	55,580
Principal payments on debt obligations	(1,186,501)	(1,234,144)
Net Cash Used in Financing Activities	(830,202)	(1,203,662)
Net (Decrease) Increase in Cash and Cash Equivalents	(12,103,280)	8,415,222
Cash and Cash Equivalents - Beginning	34,127,272	25,712,050
Cash and Cash Equivalents - End	□ 22,023,992	□ 34,127,272

Supplemental Cash Flow Information

Cash paid during the year for interest on borrowings was □1,405,775 and □1,291,943 for the years ended September 30, 2015 and 2014, respectively.

During 2015 the Network obtained various e□uipment by entering into capital leases totaling □4,840,907.

The accompanying notes are an integral part of these consolidated financial statements.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION

ORGANIZATION

Greater Waterbury Health Network, Inc. (the Corporation, Network or GWHN) was incorporated on September 27, 1984 as a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation's subsidiaries and affiliates are The Waterbury Hospital (the Hospital), Greater Waterbury Health Services, Inc., Greater Waterbury Management Resources, Inc. (GWMRI), VNA Health at Home, Inc. (VNA), and the Children's Center of Greater Waterbury Health Network, Inc. (Children's Center). The accompanying financial statements also include Access Rehab Centers, LLC (Access), Greater Waterbury Imaging Center Limited Partnership (GWIC), Imaging Partners, LLC, Alliance Medical Group, Inc. (AMG) and Cardiology Associates of Greater Waterbury, LLC to the extent of the Hospital's ownership interest in these subsidiaries and affiliated entities.

On April 30, 2015, GWHN entered into a letter of intent with Prospect Medical Holdings, Inc. ("Prospect") pursuant to which Prospect will purchase substantially all of the assets of GWHN and its affiliates, other than HAIC, the Hospital's captive insurer and Children's Center of Greater Waterbury Health Network, Inc. The transaction is subject to the approval of the Connecticut Office of the Attorney General and the Connecticut Department of Public Health's Office of Health Care Access. Those applications have been filed and are pending.

During November 2010, the Hospital established a limited liability company by the name of Cardiology Associates of Greater Waterbury, LLC (CAGW) to operate a cardiology practice. CAGW acquired the assets of Cardiology Associates of Waterbury (CAW), an unaffiliated entity, that were used by CAW physicians in the performance of their professional services.

The Hospital also acquired the assets of CAW that were used by CAW to perform diagnostic ancillary services. The Hospital converted these ancillary services to provider-based services, which are provided at a diagnostic center located near the Hospital. The goodwill recorded on the consolidated balance sheets relates to the purchase of CAW.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

ORGANIZATION (CONTINUED)

During June 2010, the Hospital entered into an arrangement with certain gastroenterology physician-members of the Hospital's medical staff to form Waterbury Gastroenterology Co-Management Company, LLC (GI Co-Management Company), a Connecticut limited liability company. This company was formed as a collaborative effort between the Hospital and the physicians for the purpose of improving the quality and efficiency of the gastroenterology service line at the Hospital. The Hospital's investment of $50,000 in the GI Co-Management Company is included in the Corporation's consolidated financial statements in long-term investments and is recorded at cost.

The Hospital entered into a members' agreement, making it an equal member with St. Mary's Hospital, located in Waterbury, Connecticut, in a joint venture to form The Harold Leever Regional Cancer Center, Inc. (the Cancer Center). The Cancer Center is a Connecticut non-stock corporation exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The purpose of the joint venture is to develop, construct, own and operate the Cancer Center. Both member hospitals transferred the revenue and related expenses of their respective radiation oncology services to the Cancer Center in October 2002. Both member hospitals made working capital advances to the Cancer Center. The Cancer Center is not included in the Hospital's consolidated financial statements. During the years ended September 30, 2015 and 2014, the Cancer Center provided unrestricted grants of $500,000 and $1,000,000, respectively, to the Hospital that are included in unrestricted gifts and bequests in the consolidated statements of operations and changes in net assets.

The Corporation's major accounting policies are as summarized below and in Note 2.

PRINCIPLES OF CONSOLIDATION

The consolidated financial statements include the accounts of the Corporation, its subsidiaries and affiliated entities. Recognition has been given to noncontrolling interests in the affiliates which is reflected as a component of unrestricted net assets. All significant intercompany accounts and transactions are eliminated in consolidation.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated uncollectible accounts receivable for services to patients, and liabilities, including estimated net settlements with third-party reimbursement agencies and professional and pension liabilities, and disclosure of contingent assets and contingent liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term. Actual results could differ from those estimates.

RECLASSIFICATIONS

Certain 2014 amounts were reclassified to conform to the 2015 presentation.

REGULATORY MATTERS

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily restricted net assets are available to provide grant related services, free care, and educational seminars. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity or in funds held in trust by others.

DONOR RESTRICTED GIFTS

Unconditional promises to give cash are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises to give are received. Amortization of the discounts is included in gifts and bequests on the consolidated statements of operations and changes in net assets.

Gifts are reported as either temporarily or permanently restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

CASH AND CASH EQUIVALENTS

The Corporation considers all highly liquid investments with remaining maturities of three months or less at date of purchase to be cash equivalents. Cash and cash equivalents are held at a limited number of financial institutions and at times, the amounts on deposit exceed insured limits.

RESTRICTED CASH

At September 30, 2015 and 2014, the Hospital had a $4.5 million surety bond with an insurance company to support its self-insured workers' compensation program that was collateralized by a bank account, which is reflected within restricted cash on the consolidated balance sheet. As of September 30, 2015 and 2014, there were no borrowings on the surety bond.

ACCOUNTS RECEIVABLE

Patient accounts receivable result from the health care services provided by the Corporation and its subsidiaries. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts.

The amount of the allowance for doubtful accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See Note 2 for additional information relative to net patient service revenues and third-party payor programs.

INVENTORIES

Inventories are stated at the lower of cost or market. The Corporation values its inventories using the first-in first-out method.

INVESTMENTS

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) and unrealized gains and losses are included in the deficiency of revenues over expenses unless the income or loss is restricted by donor or law.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INVESTMENTS (CONTINUED)

Unrealized gains and losses on investments related to permanently restricted net assets and certain temporarily restricted net assets are included in temporarily restricted net assets under State law which allows the Board of Directors to appropriate as much of the net appreciation of investments as is prudent considering the Hospital's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions. Reference is made to Note 5.

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment are recorded at cost. The Corporation and its subsidiaries provide for depreciation of property, plant and equipment and amortization of assets recorded under capital leases using the straight-line method in amounts sufficient to amortize the cost of the assets over their estimated useful lives which range from 3 to 40 years.

Financial Accounting Standards Board (FASB) ASC 410-20, *Accounting for Asset Retirement Obligations* (ASC 410-20), provides guidance on accounting and reporting for obligations associated with the retirement of tangible long-lived assets and the associated asset retirement costs. Asset retirement obligations include, but are not limited to, certain types of environmental issues which are legally required to be remediated upon an asset's retirement as well as contractually required asset retirement obligations. ASC 410-20 provides clarifying guidance on conditional asset retirement obligations. Conditional asset retirement obligations are obligations whose settlement may be uncertain. ASC 410-20's guidance requires such conditional asset retirement obligations to be estimated and recognized.

Conditional asset retirement obligations of $2,898,529 and $2,801,923 as of September 30, 2015 and 2014, respectively, are recorded in other noncurrent liabilities related to future asbestos remediation. During 2015 and 2014, there were no retirement obligations incurred or settled.

GOODWILL

Goodwill, which has an indefinite life, is not amortized and is evaluated for impairment at least annually or whenever events or business conditions indicate that the carrying values of such assets may not be fully recoverable.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

IMPAIRMENT OF LONG-LIVED ASSETS

The Corporation records impairment losses on long-lived assets used in operations when events and circumstances indicate that the assets might be impaired and the undiscounted cash flows estimated to be generated by those assets are less than the carrying amounts of those assets. There were no impairment losses recorded in 2015 and 2014.

DEFICIENCY OF REVENUES OVER EXPENSES

The consolidated statements of operations and changes in net assets include the deficiency of revenues over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from the deficiency of revenues over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), pension liability adjustments, and interest rate swap adjustments.

NEW ACCOUNTING PRONOUNCEMENT

Accounting Standards Update (ASU) No. 2013-06, *Services Received from Personnel of an Affiliate (for which the affiliate does not seek compensation)*, addresses how a receiving nonprofit organization should recognize and measure the receipt of services from personnel of an affiliate when the affiliate does not charge for reimbursement of its costs for these services. A recipient nonprofit organization is required to measure services received from personnel of an affiliate at the cost recognized by the affiliate for the personnel providing those services and if the cost amount for the services received significantly differs from the value received, the recipient nonprofit organization can elect to measure those personnel services received at fair value.

The Corporation adopted the provisions of ASU 2013-06 during the year ended September 30, 2015. The adoption of this guidance did not have a material impact on the Corporation's consolidated financial statements for the year ended September 30, 2015.

INCOME TAXES

The Corporation and its subsidiaries, with the exception of GWMRI, Access, GWIC, CAGW, AMG and Imaging Partners LLC, are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c)(3) of the Internal Revenue Code (Code). GWMRI has no current federal tax liability due to net operating losses since its date of incorporation. The Corporation is also exempt from state income tax.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INCOME TAXES (CONTINUED)

Access, GWIC, CAGW and Imaging Partners LLC are partnerships. For tax purposes, these partnerships are pass-through entities. Taxation does not occur at the partnership level. Accordingly, no provision for taxes is included.

GWMRI has approximately $5,800,000 in net operating losses. This results in a deferred tax asset of $2,720,000 which is offset by a corresponding valuation allowance of the same amount.

Management has analyzed the tax positions taken and has concluded that as of September 30, 2015, there are no uncertain tax positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Corporation is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes the Corporation is no longer subject to income tax examinations prior to 2012.

MEDICAL MALPRACTICE AND WORKERS' COMPENSATION INSURANCE

The Hospital has a policy of self-insuring the deductible portion of its workers' compensation claims. The deductible limit is $750,000 per claim for the years ended September 30, 2015 and 2014. Management records its best estimate of losses as they occur. The accrued workers' compensation self-insurance liabilities of $10,250,333 and $10,670,607 at September 30, 2015 and 2014, respectively, have been discounted at 2.25%.

Effective October 1, 2006, the Hospital obtained "claims-made" medical malpractice insurance coverage, through the Network, from Healthcare Alliance Insurance Company, Ltd. (HAIC) under retrospectively-rated policies whose ultimate premium is based primarily on the Hospital's experience. HAIC is a multi-provider captive insurance company domiciled in the Cayman Islands. The Network is a one half owner of HAIC with one other local hospital that also holds a 50% ownership. The Hospital's insurance coverage is $1,500,000 per occurrence and $5,000,000 in the aggregate. In addition to the coverage from HAIC, the Hospital recorded reserves of approximately $1,647,702 and $1,747,604 which is reflected within other noncurrent liabilities on the consolidated balance sheet at September 30, 2015 and 2014, respectively, related to claims that were incurred subsequent to October 1, 2006, but not yet reported. These reserves were discounted at 2.25% at September 30, 2015 and 2014.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

MEDICAL MALPRACTICE AND WORKERS' COMPENSATION INSURANCE (CONTINUED)

The Hospital also obtains excess insurance coverage for professional and general liability, through the Network, from HAIC. These policies have limits of $25,000,000 per claim and $25,000,000 aggregate, in excess of the underlying limits in the primary layer, for both professional and general liability.

The Hospital also purchased a loss transfer insurance policy which provides $1,000,000 of coverage for each medical incident that was incurred between October 1, 2003 and October 1, 2006 and specifically reported to the insurance company on the effective date of the transfer policy (February 7, 2008) in addition to medical incidents incurred during the aforementioned period which are first reported after the effective date of the policy. This policy also provides $1,000,000 of coverage for general liability incurred but not reported claims that occurred after October 1, 2003 through October 1, 2006 and were first reported after the effective date of the policy. The policy has annual aggregate limits of $4,500,000 for medical incidents and $3,000,000 for general liability cases with a combined $25,000,000 total limit for all policy years. These aggregate limits are eroded by claims previously paid by the Hospital or other insurance.

RETIREMENT BENEFIT PLANS

The Hospital maintains a defined benefit pension plan for eligible individuals and participates in two multi-employer pension plans that cover certain union employees. Reference is made to Note 9.

OTHER NONCURRENT LIABILITIES

Other noncurrent liabilities include the long-term portion of liabilities for medical malpractice, workers' compensation, retirement benefits, the interest rate swap, and conditional asset retirement obligations.

RISKS AND UNCERTAINTIES

The Corporation invests in a variety of investment securities which are exposed to various risks, such as interest rate risk, financial market risk, currency risk and credit risk. Due to the level of risk associated with investment securities, coupled with economic events, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the Corporation's September 30, 2015 financial statements, in addition to the funded status of its defined benefit pension plan.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

BAD DEBTS

ASU 2011-07, *Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*, requires certain health care entities to present the provision for bad debts associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense with enhanced footnote disclosures on the policies for recognizing revenue and assessing bad debts, in addition to qualitative and quantitative information about changes in the allowance for doubtful accounts. Refer to Note 2 for the additional disclosures required by ASU 2011-07.

NOTE 2 – NET PATIENT SERVICE REVENUES AND CHARITY CARE

The following summarizes net patient service revenues:

	2015	2014
Gross patient service revenues	$1,002,524,595	$991,028,165
Deductions:		
Allowances	757,264,117	735,776,916
Regulatory	7,110,830	1,857,243
	764,374,947	737,634,159
Net patient service revenues, before provision for bad debts	238,149,648	253,394,006
Provision for bad debts	4,483,187	4,454,817
Net patient service revenues less provision for bad debts	$ 233,666,461	$248,939,189

Patient accounts receivable and revenues are recorded when patient services are performed.

Amounts received from most payors are different from the established billing rates of the Hospital, and these differences are accounted for as allowances. Net revenues have been affected by State of Connecticut Disproportionate Share program in 2015 and 2014 which is reflected in the regulatory amounts in the table above.

NOTE 2 – NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. For the years ended September 30, 2015 and 2014, the Corporation recorded approximately $3,000,000 and $2,500,000, respectively, as a decrease to net patient service revenues as changes in estimates related to third-party payor settlements and adjustments to accruals recorded in prior years.

During 2015 and 2014 approximately 40% and 44%, respectively, of net patient service revenues were received under the Medicare program, 17% and 10%, respectively, under the state Medicaid program, and 43% and 46%, respectively, from contracts with other third-parties.

Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital. The State of Connecticut has implemented reductions in the State's Disproportionate Share Reimbursement Program for the period from July 1, 2012 through June 30, 2015.

The current Connecticut Medicaid inpatient hospital reimbursement model of interim per diem rates and case rate settlements transitioned effective January 1, 2015 to an All Patient Refined Diagnosis Related Group System (APR-DRG) where hospital payments are established prospectively. Connecticut Medicaid outpatient hospital reimbursement will move from the current system of reimbursement based on Revenue Center Codes to a prospective payment system based on the complexity of services performed. The specific outpatient plan has not been finalized by the State of Connecticut, but the new outpatient reimbursement methodology will not be implemented until at least the second half of fiscal year 2016.

The significant concentrations of net accounts receivable for services to patients include 41% from Medicare, 16% from Medicaid, 28% from commercial insurance carriers and 15% from others at September 30, 2015 (44%, 15%, 28% and 13%, respectively, in 2014).

NOTE 2 – NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. The Corporation believes that it is in compliance with all applicable laws and regulations. Cost reports for the Hospital, which serve as a basis for final settlement with government payors, have been settled by final settlement through 2012 for Medicare and 1995 for Medicaid. Other years remain open for settlement.

The Corporation has agreements with various Health Maintenance Organi□ations (HMOs) to provide medical services to subscribing participants. Under these agreements, the HMOs make fee-for-service payments to the Corporation for certain covered services based upon discounted fee schedules.

ALLOWANCE FOR DOUBTFUL ACCOUNTS

The Corporation□s estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Corporation□s collection efforts. The Corporation□s policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as the charges are recorded. On a monthly basis, the Corporation reviews its accounts receivable balances, the effectiveness of the Corporation□s reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

- Revenue and volume trends by payor, particularly the self-pay components;
- Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;
- Various allowance coverage statistics.

The Corporation regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for doubtful accounts.

NOTE 2 – NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

ALLOWANCE FOR DOUBTFUL ACCOUNTS (CONTINUED)

A summary of the Corporation's allowance for doubtful accounts activity for the years ended September 30, 2015 and 2014 is as follows:

	Balance at Beginning of Period	Additions Recorded in the Provision for Bad Debts	Accounts Written off, Net of Recoveries and Other	Balance at End of Period
Allowance for doubtful accounts:				
Year ended September 30, 2014	(15,090,000)	(4,454,817)	10,256,817	(9,288,000)
Year ended September 30, 2015	(9,288,000)	(4,483,187)	8,539,187	(5,232,000)

MEASURING CHARITY CARE

The Corporation accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Corporation. Essentially, these policies define charity services as those services for which no payment is possible. In assessing a patient's inability to pay, the Corporation utilizes the generally recognized Federal poverty income levels, but also includes certain cases where incurred charges are significant when compared to incomes and assets. These services are not included in net patient service revenues for financial reporting purposes.

The Hospital implemented effective October 1, 2013, a change to its charity care policy to discount all self-pay receivables by 50 percent upon final billing. These self-pay discounts amounted to approximately 5.3 million and 5.2 million for the years ended September 30, 2015 and 2014, respectively.

Self-pay revenues are derived primarily from patients who do not have any form of health care coverage. The Corporation evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the Corporation's policy for charity care. The Corporation provides care without charge to certain patients that qualify under its charity care policy. For the years ended September 30, 2015 and 2014, the Corporation estimates that its costs of care provided under its charity care programs approximated 1,212,000 and 1,383,000, respectively.

NOTE 2 – NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

MEASURING CHARITY CARE (CONTINUED)

The Corporation's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Corporation's gross charity care charges provided. The Corporation's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Corporation's charity care policy. To the extent the Corporation receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Corporation does not include these patients' charges in its cost of care provided under its charity care program. Additionally, the Corporation does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Corporation's policy not to pursue collection of amounts related to these patients.

ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS

The American Recovery and Reinvestment Act of 2009 (ARRA) included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are also available to providers that adopt, implement or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

Income from Medicare incentive payments is recognized as revenue after the Hospital has demonstrated that it complied with the meaningful use criteria over the entire applicable compliance period. The Hospital recognized revenue from Medicaid and Medicare for incentive payments after it adopted certified EHR technology. There were no payments received during 2015 from this incentive program. Medicaid incentive payments were $322,653 for the year ended September 30, 2014. Medicare incentive payments were $1,184,857 for the year ended September 30, 2014. The Hospital has not recognized estimated incentive payments of $646,000 for 2015 as the Hospital has not yet attested to meeting the necessary requirements. Incentive payments are included in other operating revenues in the accompanying consolidated statements of operations and changes in net assets. Income from incentive payments is subject to retrospective adjustment as the incentive payments are calculated using Medicare cost report data that is subject to audit. Additionally, the Hospital's compliance with the meaningful use criteria is subject to audit by the federal government.

NOTE 3 – INVESTMENTS

The composition of investments, including funds held in escrow, is set forth in the following table. Investments are stated at fair value:

	2015		2014	
	Cost	Fair Value	Cost	Fair Value
Short-term investments:				
U.S. Treasury notes and other bonds	$ 52,002	$ 55,480	$ 62,002	$ 67,080
Marketable equity securities	224,663	384,473	204,422	351,245
Mutual funds	937,032	1,075,476	793,483	955,553
Certificates of deposit and money market funds	12,099	12,099	46,855	46,855
	$ 1,225,796	$ 1,527,528	$ 1,106,762	$ 1,420,733
Escrow funds for long-term debt:				
Cash and money market funds	$ 31,682	$ 31,682	$ 32,613	$ 32,613
Investments of funds held in trust by others	$42,606,849	$43,411,397	$42,013,991	$46,117,761
Long-term investments and Board-designated endowment funds:				
Certificates of deposit and money market funds	$ 1,408,897	$ 1,408,897	$ 1,463,914	$ 1,437,247
Marketable equity securities	198,290	364,337	198,290	351,693
U.S. Government obligations	108,451	148,198	108,451	149,445
Corporate bonds	2,659,057	2,632,832	3,680,469	3,686,721
Annuity contract	100,000	198,564	100,000	190,652
Mutual funds	19,946,518	19,764,493	21,246,603	22,793,639
	$24,421,213	$24,517,321	$26,797,727	$28,609,397

NOTE 3 – INVESTMENTS (CONTINUED)

The Corporation had long-term investments in partnerships and joint ventures that were recorded at cost of $1,385,832 and $1,643,954 as of September 30, 2015 and 2014, respectively, as it was not practicable to estimate fair value. These investments are not included in the tables above.

Unrestricted investment income, including income on funds held in trust by others, and gains are comprised of the following for the years ended September 30, 2015 and 2014:

	2015	2014
Income:		
Interest and dividends	$ 1,475,309	$ 1,376,149
Realized (losses) gains on sales of investments	400,707	330,092
Changes in unrealized (losses) gains on investments	(1,197,928)	294,354
	$ 678,088	$ 2,000,595

NOTE 4 – FAIR VALUE MEASUREMENTS

The Corporation categorizes assets and liabilities for disclosure purposes based on whether the inputs used to determine their fair values are observable or unobservable. The Corporation utilizes a three-level fair value hierarchy that prioritizes the inputs used to measure assets at fair value. Level inputs are as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Corporation has the ability to access on the reporting date.

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset.

Level 3 – Inputs that are unobservable for the asset or liability.

NOTE 4 – FAIR VALUE MEASUREMENTS (CONTINUED)

The fair values of Level 1 securities were determined through quoted market prices, while fair values of Level 2 securities were determined primarily through prices obtained from third party pricing sources, where quoted market prices for such securities are not available. The fair values of Level 3 securities were determined primarily through information obtained from the relevant counterparties for such assets and liabilities, as information on which these fair values are based is generally not readily available in the market.

The fair value of the interest rate swap was determined based on an estimate of the net present value of the expected cash flows using relevant mid-market data inputs and based on the assumptions of no unusual market conditions or forced liquidation.

The following table summarizes fair value measurements, by level, at September 30, 2015, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Investment Assets (Fair Value) as of September 30, 2015			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 27,556,405	$ --	$ --	$ 27,556,405
Common stock-insurance	156,240	--	--	156,240
Mutual funds:				
U.S. large cap	20,486,069	--	--	20,486,069
U.S. mid cap	2,952,563	--	--	2,952,563
U.S. small cap	2,604,780	--	--	2,604,780
International developed	7,656,570	--	--	7,656,570
Emerging markets	2,273,498	--	--	2,273,498
Fixed income securities:				
Investment grade taxable	2,928,024	10,166,399	--	13,094,423
International developed bonds	--	678,855	--	678,855
Global high yield taxable	4,990	1,850,028	--	1,855,018
Intermediate-term bond	9,696,365	--	--	9,696,365
Real estate investment trusts	2,382,816	--	--	2,382,816
Other	1,138,690	297,946	--	1,436,636
Total investments at fair value	$ 79,837,010	$ 12,993,228	$ --	$ 92,830,238
Liabilities:				
Interest rate swap	$ --	$ 1,851,544	$ --	$ 1,851,544

NOTE 4 – FAIR VALUE MEASUREMENTS (CONTINUED)

The following table summarizes fair value measurements, by level, at September 30, 2014, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Investment Assets (Fair Value) as of September 30, 2014			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 38,733,129	$ --	$ --	$ 38,733,129
Common stock-insurance	133,496	--	--	133,496
Mutual funds:				
U.S. large cap	34,249,935	--	--	34,249,935
U.S. mid cap	3,399,506	--	--	3,399,506
U.S. small cap	2,786,261	--	--	2,786,261
International developed	5,657,490	--	--	5,657,490
Emerging markets	3,076,127	--	--	3,076,127
Fixed income securities:				
Investment grade taxable	2,891,796	12,122,021	--	15,013,817
International developed bonds	--	695,404	--	695,404
Global high yield taxable	5,296	2,420,636	--	2,425,932
Real estate investment trusts	2,507,053	--	--	2,507,053
Other	1,758,038	546,588	--	2,304,626
Total investments at fair value	$ 95,198,127	$ 15,784,649	$ --	$ 110,982,776
Liabilities:				
Interest rate swap	$ --	$ 1,512,596	$ --	$ 1,512,596

NOTE 5 – RESTRICTED ENDOWMENTS

The Hospital's endowments consist of donor-restricted endowment funds and Board-designated endowment funds. Net assets associated with endowment funds are classified and reported based on donor-imposed restrictions.

The Hospital's Board of Trustees has interpreted the Connecticut Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and, if applicable (c) accumulations to the permanent endowment made in accordance with the related gift's donor instructions. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard for expenditure as proscribed by UPMIFA. In accordance with UPMIFA, the Corporation considers the following factors in making determinations to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund
(2) The purposes of the Hospital and the donor-restricted endowment fund
(3) General economic conditions
(4) The possible effect of inflation and deflation
(5) The expected total return from income and the appreciation of investments
(6) Other resources of the Hospital
(7) The investment policies of the Hospital

RETURN OBJECTIVES AND RISK PARAMETERS

For the permanently restricted endowment funds, the bank, acting in its capacity as trustee, determines and directs the investment policy and asset allocation. For the unrestricted and temporarily restricted endowment funds, the Corporation's Board of Directors has adopted investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. The Hospital expects these endowment funds, over time, to provide an average rate of return that exceeds the rate of inflation by 3.5% annually. Actual returns in any given year may vary from this amount.

NOTE 5 – RESTRICTED ENDOWMENTS (CONTINUED)

STRATEGIES EMPLOYED FOR ACHIEVING OBJECTIVES

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

SPENDING POLICY AND HOW THE INVESTMENT OBJECTIVES RELATE TO SPENDING POLICY

The Hospital has a policy of evaluating the spending decisions for each endowment fund based upon the intentions of the donors and specific contractual agreements. In determining the annual amount to be spent, the Hospital considers the long-term expected return on its endowment. The spending policy is designed to limit spending to the expected long-term real rate of return. The annual distribution from the endowment funds is expected to be contained within a range of 4-6% of the funds' market value. This is consistent with the Hospital's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2015

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 7,049,429	$ 46,203,433	$ 53,252,862

NOTE 5 – RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2015

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 3,315,500	$ 7,607,185	$ 48,909,797	$ 59,832,482
Investment return:				
Investment income	140,679	445,901	--	586,580
Net depreciation (realized and unrealized)	(118,499)	(566,800)	(2,706,364)	(3,391,663)
Total investment return	22,180	(120,899)	(2,706,364)	(2,805,083)
Appropriation of endowment assets for expenditure	(3,337,680)	(436,857)	--	(3,774,537)
Endowment net assets, ending balance	$ --	$ 7,049,429	$ 46,203,433	$ 53,252,862

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2014

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 7,607,185	$ 48,909,797	$ 56,516,982
Board-designated endowment funds	3,315,500	--	--	3,315,500
Total funds	$ 3,315,500	$ 7,607,185	$ 48,909,797	$ 59,832,482

NOTE 5 – RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2014

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 3,193,664	$ 7,446,152	$ 47,752,075	$ 58,391,891
Investment return:				
Investment income	56,642	184,580	--	241,222
Net appreciation (realized and unrealized)	203,276	612,338	1,157,722	1,973,336
Total investment return	259,918	796,918	1,157,722	2,214,558
Appropriation of endowment assets for expenditure	(138,082)	(635,885)	--	(773,967)
Endowment net assets, ending balance	$ 3,315,500	$ 7,607,185	$ 48,909,797	$ 59,832,482

NOTE 6 – TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Permanently restricted net assets at September 30, 2015 and 2014, are restricted amounts which are to be held in perpetuity, the income from which is expendable to provide free care, scholarships for the children of the Hospital's employees, and for the operations of the Hospital. Also included in permanently restricted net assets are funds held in trust by others. The Hospital is the restricted income beneficiary of funds held in trust by others. The total trust assets, as reported by the trustee, had an aggregate fair value at September 30, 2015 and 2014 of $43,411,397 and $46,117,761, respectively. Distributions of $1,996,055 and $2,023,580 from these assets for the years ended September 30, 2015 and 2014, respectively, are included in investment income.

Temporarily restricted net assets are available to provide psychiatric services, free care and educational seminars.

NOTE 6 – TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS (CONTINUED)

During 2015 and 2014, net assets were released from donor restrictions by incurring expenses which satisfied the restricted purposes in providing grant related services, free care, and various miscellaneous services in the amounts of $4,010,322, $692,333 and $311,774, respectively in 2015 and $4,369,303, $688,243 and $484,945, respectively in 2014. In addition, $95,170 and $13,360 were released for the purchase of property and equipment in 2015 and 2014, respectively.

NOTE 7 – DEBT

HOSPITAL SERIES D BOND FINANCING

In December 2010, the Hospital refinanced its Series C bond financing and financed an additional $8,000,000 for various capital projects that were completed over a two-year period. The par amount of the Series D debt was $25,918,000 and interest is variable at the interest rate that is equal to the product of (i) sixty-eight percent (68%) and (ii) the sum of the LIBOR Rate and three hundred basis points (2.18% and 2.15% at September 30, 2015 and 2014, respectively). The bonds require monthly principal and interest payments, based upon a 10-year amortization schedule, from 2011 through 2020 with the remaining principal balance due in 2020.

The terms of the bonds provide for, among other things, a pledge of gross receipts of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and provide for covenants regarding the Hospital's debt service coverage ratios, minimum levels of cash on hand, sale and lease of assets and other covenants similar in financings of this type.

In connection with this refinancing, the Hospital entered into an interest rate swap with a bank, which allowed it to convert its variable interest rate liability to a fixed interest rate liability of 4.475% without changing the structure of the underlying debt.

The Hospital uses the interest rate swap agreement to manage interest rate risk associated with its outstanding debt. At September 30, 2015 and 2014, the notional value of outstanding interest rate swap was $23,789,744 and $24,283,520, respectively.

The Hospital recognizes the fair value of its interest rate swap in the consolidated balance sheet as a liability, recorded in other noncurrent liabilities. At September 30, 2015 and 2014, the fair value of interest rate swap was in a liability position of $1,851,544 and $1,512,596, respectively.

The Hospital designated its interest rate swap as a cash flow hedge for accounting purposes, and accordingly defers gains or losses associated with the swap in net assets.

NOTE 7 – DEBT (CONTINUED)

HOSPITAL SERIES D BOND FINANCING (CONTINUED)

During fiscal year 2015, GWHN failed to meet certain of the financial covenants with respect to the Series D Bonds. On December 14, 2015, GWHN entered into a forbearance agreement with the holder of the Series D Bonds, which provided for the payment of a forbearance fee and a default rate of interest, the engagement of a chief restructuring officer, the modification of certain financial and reporting covenants, a mortgage on certain additional real property of the Hospital and a security interest in certain of the Hospital's personal property. The forbearance period concludes at the earlier of October 1, 2016 or the closing of the sale of the Hospital. The forbearance fee and the amount of the increase in the interest rate over pre-forbearance rate of interest are deferred until the end of the forbearance period.

CHILDREN'S CENTER SERIES 2011 BONDS

In August 2011, CHEFA sold $28,840,000 of Series 2011 revenue bonds, the proceeds of which were used to redeem a number of bond series. As a result of the sale of the Series 2011 bonds, the Children's Center's loan with CHEFA was refinanced and reduced from $1,560,000 to $1,505,000. The Series 2011 bonds mature serially from 2012 through 2030, with interest rates ranging from 1% to 5%.

Under the terms of the financing arrangements between the Children's Center and CHEFA, the proceeds of the revenue bonds were loaned to the Children's Center. Pursuant to the loan agreement, the Children's Center was obligated to provide amounts which will be sufficient to enable CHEFA to pay the principal of and interest on the proceeds of the Series 2011 Bonds.

Concurrently with the issuance and delivery of the Series 2011 Bonds, the Children's Center and U.S. Bank NA, as trustee, entered into the Master Indenture and Supplemental Master Indentures Numbers 1 and 2, pursuant to which the Children's Center was obligated to pay the amount due under the loan agreement with CHEFA. The Master Indenture and Supplemental Master Indentures provide for, among other things, the establishment and maintenance of a Debt Service Reserve Fund (which has been funded by the State of Connecticut as discussed below) and a pledge of the gross receipts, as defined, of the Children's Center, restriction on the incurrence of certain indebtedness of the Children's Center and covenants regarding the Children's Center's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type.

Pursuant to Public Act No. 97-259 (the School Readiness Act), the State of Connecticut has encouraged the development of a network of school readiness programs that meet the standards developed by the State Department of Education.

NOTE 7 – DEBT (CONTINUED)

CHILDREN'S CENTER SERIES 2011 BONDS (CONTINUED)

To encourage such development, the School Readiness Act established, among other things, the Child Care Facilities Program to finance low interest loans for the purpose of new construction of child care centers. The State of Connecticut, acting through the Commissioner of the Department of Social Services, may allow actual debt service on such loans and a debt service reserve fund to be paid by the State of Connecticut provided that such debt service terms are determined by the Commissioner to be reasonable. The State of Connecticut has funded the debt service reserve fund and has agreed to fund, subject to available appropriations, 83.6% of the debt service on the Series 2011 Bonds and to replenish any deficiencies in the debt service reserve fund. During 2015 and 2014, the total debt service funded by the State of Connecticut was $100,466 and $104,030, respectively.

Future minimum payments by year and in the aggregate under the CHEFA bonds (including Series D and Series 2011) are as follows at September 30, 2015:

2016	$ 576,408
2017	600,080
2018	629,832
2019	655,716
2020	687,792
Aggregate thereafter	21,909,916
	$ 25,059,744

If the proposed transaction (further described in Note 1) were to close, future minimum payments related to the CHEFA bonds would be settled at closing.

OTHER DEBT

Access has a $250,000 line of credit with a bank. There were no borrowings under this line of credit at September 30, 2015 and 2014.

In April 2005, the VNA established a $500,000 line of credit with Webster Financial Advisors. The interest rate at in 2015 and 2014 was 4.25%. The line of credit is secured by the VNA's investments held by Webster Financial Advisors and a first lien on all business assets located at 27 Siemon Company Drive, Watertown, Connecticut. There were no advances on the line of credit at September 30, 2015 and 2014.

NOTE 7 – DEBT (CONTINUED)

OTHER DEBT (CONTINUED)

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $353 through March 2015 and is secured by the equipment. The balance of the capital lease liability was $zero at September 30, 2015 and $1,993 at September 30, 2014.

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $447 through May 2015 and is secured by the equipment. The balance of the capital lease liability was $zero at September 30, 2015 and $3,883 at September 30, 2014.

AMG entered into a term note during 2010 at an interest rate of 9.8%. The note calls for monthly payments of $13,216 through November 2014 and is secured by the assets of AMG. The balance of the term note liability was $zero at September 30, 2015 and $26,101 at September 30, 2014.

AMG entered into a capital lease for equipment during 2015. The lease calls for monthly payments of $100 through December 2019. The balance of the capital lease liability was $4,757 as of September 2015.

The Hospital entered into a capital lease for equipment during 2011. The lease calls for equal monthly payments of $20,450 through May 2016 and is secured by the equipment. The balance of the capital lease liability was $161,789 at September 30, 2015 and $379,070 at September 30, 2014.

The Hospital entered into a capital lease for equipment during 2012. The lease calls for equal monthly payments of $11,469 through August 2017 and is secured by the equipment. The balance of the capital lease liability was $252,912 at September 30, 2015 and $376,940 at September 30, 2014.

The Hospital entered into a capital lease for equipment during 2013. The lease calls for equal monthly payments of $4,779 through November 2015. The balance of capital lease liability was $9,491 at September 30, 2015 and $64,581 at September 30, 2014.

AMG entered into a capital lease for equipment during 2014. The balance of the capital lease liability was $34,840 at September 30, 2015 and $48,121 at September 30, 2014.

The Hospital entered into a capital lease for equipment during 2015. The lease calls for monthly payments of $44,942 through August 2018 and is secured by the equipment. The balance of the capital lease liability was $1,379,212 at September 30, 2015.

NOTE 7 – DEBT (CONTINUED)

OTHER DEBT (CONTINUED)

The Hospital entered into a capital lease for equipment during 2015. The lease calls for monthly payments of $19,220 through September 2020 and is secured by the equipment. The balance of the capital lease liability was $1,065,919 at September 30, 2015.

The Hospital entered into a capital lease for equipment during 2015. The lease calls for monthly payments of $9,138 through September 2020 and is secured by the equipment. The balance of the capital lease liability was $506,794 at September 30, 2015.

The Hospital entered into a capital lease for equipment during 2015. The lease calls for monthly payments of $34,928 through September 2020 and is secured by the equipment. The balance of the capital lease liability was $1,688,157 at September 30, 2015.

The carrying value of assets subject to capital leases were $5,401,906 and $1,204,971 at September 30, 2015 and 2014, respectively.

Future minimum payments by year and in the aggregate for all non-CHEFA obligations were as follows at September 30, 2015:

2016	$ 1,455,894
2017	1,268,566
2018	1,186,628
2019	753,759
2020	439,024
	$ 5,103,871

The fair value of the debt, using the discounted cash flow analyses, was approximately $31,903,000 and $27,958,000 at September 30, 2015 and 2014, respectively.

NOTE 8 – RENTAL EXPENSE AND LEASE COMMITMENTS

The Hospital, VNA and GWMRI have entered into operating leases for office space and office equipment. Rental expense is recorded on a straight-line basis over the terms of the leases. Rental expense for the years ended September 30, 2015 and 2014 was $4,711,947 and $4,490,046, respectively. The minimum rental commitments under all noncancellable operating leases with initial or remaining terms of more than one year are as follows:

2016	$ 3,793,327
2017	2,646,353
2018	1,367,811
2019	1,099,785
2020	87,708
Thereafter	147,201
	$ 9,142,185

NOTE 9 – EMPLOYEE BENEFIT PLANS

The Hospital has a noncontributory defined benefit cash balance plan (the Plan). Under the Plan, each participant who elected to transfer their balances to the Plan from the former defined contribution plan receives a credit of 6% of compensation allocated to their cash balance accounts. All other participants receive a 3% credit. Additionally, each participant receives an interest credit to their cash balance account based on the yield to maturity on three-year treasury bills. The Plan covers substantially all non-union employees age 21 and older with one year of service. It is the Hospital's policy to make contributions to the Plan sufficient to meet the minimum funding requirements of applicable laws and regulations.

The Plan was frozen to non-union participants effective June 30, 2015. Participants who are part of the Connecticut Healthcare Associates Technical Unit remain active in the Plan. Non-union employees no longer accrue additional employer contribution credits in the Plan. These participants will continue to receive interest credits based on their account balances in accordance with the terms of the Plan. They will be entitled to their account balance (the retirement benefit they have earned up to June 30, 2015) plus applicable interest credits after the Plan was frozen.

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

Following is a summary of the Plan's funded status using the measurement dates of September 30, 2015 and 2014 and amounts recognized in the Corporation's consolidated financial statements.

	2015	2014
Change in benefit obligation		
Benefit obligation beginning of year	$ (36,236,973)	$ (35,562,211)
Service cost	(1,210,019)	(1,466,890)
Interest cost	(1,218,771)	(1,324,043)
Actuarial loss	(318,307)	(1,095,038)
Benefits paid	2,506,357	3,211,209
Administrative expenses paid	280,850	--
Curtailments, settlements and special termination benefits	889,881	--
Benefit obligation, end of year	$ (35,306,982)	$ (36,236,973)
Change in plan assets		
Fair value of plan assets, beginning of year	$ 25,988,705	$ 27,201,671
Actual return on plan assets	(454,219)	696,625
Employer contributions	1,203,796	1,301,618
Benefits paid	(2,506,357)	(3,211,209)
Administrative expenses paid	(280,850)	--
Fair value of plan assets, end of year	$ 23,951,075	$ 25,988,705
Funded status	$ (11,355,907)	$ (10,248,268)
Accrued pension liability	$ (11,355,907)	$ (10,248,268)
Components of net periodic pension cost		
Service cost	$ 1,210,019	$ 1,466,890
Interest cost	1,218,771	1,324,043
Expected return on plan assets	(1,126,585)	(1,294,305)
Amortization of actuarial loss	1,155,130	816,016
Amortization of prior service cost	27,271	35,097
Additional amount recognized from curtailment	84,839	--
Net periodic pension cost	$ 2,569,445	$ 2,347,741
Accumulated benefit obligation	$ 35,213,276	$ 35,271,477

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

Included in unrestricted net assets are the following amounts that have not yet been recognized in net periodic cost:

	2015	2014
Unrecognized prior service cost	$ (9,324)	$ (121,434)
Unrecognized actuarial losses	(15,503,601)	(15,649,501)
	$ (15,512,925)	$ (15,770,935)

Changes in benefit obligations recognized in unrestricted net assets include:

	2015	2014
Prior service cost	$ 84,839	$ --
Current year actuarial losses	(1,009,230)	(1,692,718)
Amortization of prior service cost	27,271	35,097
Amortization of net loss	1,155,130	816,016
	$ 258,010	$ (841,605)

The prior service cost and actuarial losses included in unrestricted net assets and expected to be recognized in net periodic cost during the year ending September 30, 2016 are $27,271 and $1,322,221, respectively.

ASSUMPTIONS

The weighted-average assumptions used to determine benefit obligations at September 30 are as follows:

	2015	2014
Discount rate	3.58%	3.55%
Expected return on plan assets	4.50%	4.50%
Rate of compensation increase	2.00% for 2 year select period, 3.00% ultimate	2.00% for 2 year select period, 3.00% ultimate

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

ASSUMPTIONS (CONTINUED)

The weighted-average assumptions used to determine net periodic benefit cost for years ended September 30 are as follows:

	2015	2014
Discount rate	3.55%	3.99%
Expected return on assets	4.50%	4.50%
Rate of compensation increase	2.00% for 2 year select period, 3.00% ultimate	2.00% for 3 year select period, 3.00% ultimate

Effective September 30, 2015, the Hospital updated the mortality assumptions to align with the mortality tables and improvement scales released by the Society of Actuaries in the fall of 2015. This update resulted in an increase to the Hospital's projected benefit obligation of approximately $7,830,229 which is included in the accrued pension liability in the consolidated balance sheet as of September 30, 2015.

EXPECTED LONG-TERM RETURN ON PLAN ASSETS

To develop the expected long-term rate of return on assets assumptions, the Hospital considered the historical returns and the future expectations of returns for each asset class, as well as target asset allocations of the pension portfolio. This resulted in the selection of the 4.5%, long-term rate of return at September 30, 2015 and 2014.

INVESTMENT POLICY

The Plan's weighted-average asset allocations at September 30, 2015, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
U.S. Equity	24%	25%	20% - 30%
Non-U.S. Equity	13%	15%	10% - 20%
Core fixed income	63%	60%	55% - 65%

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

INVESTMENT POLICY (CONTINUED)

The Plan's weighted-average asset allocations at September 30, 2014, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
U.S. Equity	5%	5%	3% - 7%
Non-U.S. Equity	5%	5%	3% - 7%
Core fixed income	90%	90%	86% - 94%

The Pension Committee of the Board of Directors (the Committee) is responsible for employee benefit program policies with respect to plan assets and the retention of qualified managers, consultants and trustee/custodians. The purpose of the Committee is to ensure the Plan assets accumulate monies required to meet the anticipated benefit payments of the Plan and contributions are made by the Hospital on a basis determined by the Plan's actuary to be adequate to fund the benefits. The investment objective of the Committee is to maximize total return after inflation within the limits of prudent risk taking by diversifying across asset classes and multiple managers. The Committee has established an asset allocation policy that sets a target and range for each asset class, as shown in the table above.

CONTRIBUTIONS

The Hospital expects to make $1,276,854 in contributions to the Plan in 2016.

ESTIMATED FUTURE BENEFIT PAYMENTS

The following benefit payments, which reflect expected future service, are expected to be paid as follows:

2016	$ 3,867,000
2017	3,184,000
2018	3,192,000
2019	2,993,000
2020	2,805,000
2021-2025	12,034,000
	$ 28,075,000

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

As required by ASC 820, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

The following table sets forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2015.

	Level 1	Level 2	Level 3	Total
Commingled funds and private equity	$ --	$ --	$ 23,951,075	$ 23,951,075

The following table sets forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2014.

	Level 1	Level 2	Level 3	Total
Commingled funds and private equity	$ --	$ --	$ 25,988,705	$ 25,988,705

The following is a reconciliation of Level 3 assets, collective investments and common trust funds, for which significant unobservable inputs were used to determine fair value:

	2015	2014
Balance as of beginning of fiscal year	$ 25,988,705	$ 27,201,671
Change in unrealized (depreciation) appreciation	(565,059)	570,424
Purchases	11,621,663	5,571,007
Sales	(13,094,234)	(7,354,397)
Balance as of September 30,	$ 23,951,075	$ 25,988,705

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

OTHER BENEFIT PLANS

The Hospital participates in multi-employer pension plans that cover substantially all union employees. Contributions to the plans are based upon a percentage of each participant's total salary. The risks of participating in these multi-employer plans are different from single-employer plans in the following aspects:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of another participating employer.

- If a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers.

- If the Hospital chose to stop participating in the multi-employer plans, the Hospital may be required to pay those plans an amount based on the underfunded status of the plans, referred to as a withdrawal liability.

The following table presents the Hospital's participation in these plans as of and for the years ended September 30, 2015 and 2014.

Pension Trust Fund	Pension Plan Employer Identification Number	Pension Protection Act ("PPA") Certified Zone Status[1]		FIP/RP Status Pending/ Implemented[2]	Contributions		Surcharge Imposed	Expiration Date of Collection Bargaining Agreement[3]
		2015	2014		2015	2014		
Connecticut Health Care Associates Pension Fund	06-1313462	Green	Green	N/A	$ 1,966,612	$ 2,074,142	No	September 30, 2017
New England Health Care Employees Pension Fund	22-3071963	Green	Green	N/A	647,943	688,949	No	February 29, 2016
				Total Contributions:	$ 2,614,555	$ 2,763,091		

[1] The most recent PPA zone status available in 2015 and 2014 is for the plan's year-ending during 2014 and 2013, respectively. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.

[2] The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented.

[3] Lists the expiration dates of the collective-bargaining agreements to which the plans are subject.

During the years ended September 30, 2015 and 2014, the Hospital's contributions to the Connecticut Health Care Associates Pension Plan represented 98.7% and 98.6% of the total contributions made to the plan by all participating employers, respectively.

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

During the years ended September 30, 2015 and 2014, the Hospital's contributions to the New England Health Care Employees Pension Plan represented 2.8% of the total contributions made to the plan by all participating employers.

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. The Hospital has explored the costs to withdraw from the Connecticut Health Care Associates (CHCA) Pension Plan in the event that the Hospital enters into a transaction. If the Hospital was to withdraw, it is expected that CHCA will likewise withdraw from the pension plan making a total withdrawal liability for the Hospital of approximately $27,700,000.

The VNA has a defined contribution pension plan which covers substantially all full-time employees, in addition to a non-contributory discretionary pension plan for which contributions are made annually at the discretion of the VNA's Board of Directors.

In addition, the Hospital has a supplemental employee retirement plan for certain executives. The plan provides for a total benefit and is partially funded. As of September 30, 2015 and 2014, liabilities of $424,337 and $330,148, respectively, have been reflected in the consolidated balance sheets.

As noted above, the Hospital also has a noncontributory defined benefit cash balance plan covering substantially all non-union employees age 21 and older with one year of service. Total pension expense, relating to this plan, charged to operations during the years ended September 30, 2015 and 2014 was $2,569,445 and $2,347,741, respectively.

NOTE 10 – SELF INSURANCE CLAIMS

There have been medical malpractice and workers' compensation claims that fall within the Corporation's partially self-insured program which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2015 that may result in the assertion of claims. Corporation management has accrued its best estimate of these contingent losses. Other claims may be asserted arising from services provided to patients or workers' compensation incidents in the past. Corporation management has provided reserves for these contingent liabilities.

NOTE 11 – CONTINGENCIES

The Corporation is a party to various lawsuits incidental to its business. The ultimate outcome is not determinable at this time.

NOTE 12 – DUE FROM AFFILIATES

The amounts due from affiliates of □189,380 and □190,880 at September 30, 2015 and 2014, respectively, represent receivables from affiliates that do not eliminate in consolidation. These balances are comprised of the following:

	2015	2014
Alliance Medical Group	□ 187,880	□ 187,880
GI Co-Management Company	1,500	3,000
	□ 189,380	□ 190,880

NOTE 13 – FUNCTIONAL EXPENSES

The Corporation provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows:

	2015	2014
Health care services	□203,231,532	□199,171,604
General and administrative	64,486,347	68,892,466
Fundraising	335,025	386,125
	□268,052,904	□268,450,195

NOTE 14 – SUBSEQUENT EVENTS

The Network evaluates the impact of subsequent events, events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date or for disclosure in the notes to the financial statements. The Network evaluated events occurring subsequent to September 30, 2015 through January 18, 2016, the date on which the accompanying consolidated financial statements were available to be issued. During this period, there were no subsequent events that required recognition in the consolidated financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

SEPTEMBER 30, 2013 AND 2012

GREATER WATERBURY HEALTH NETWORK, INC.
AND SUBSIDIARIES

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MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT

Board of Directors
Greater Waterbury Health Network, Inc.

We have audited the accompanying consolidated financial statements of Greater Waterbury Health Network, Inc., which comprise the consolidated balance sheets as of September 30, 2013 and 2012, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards re□uire that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors□ judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity□s preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity□s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting polices used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Greater Waterbury Health Network, Inc. as of September 30, 2013 and 2012, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Marcum LLP

Hartford, CT
January 10, 2014

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

SEPTEMBER 30, 2013 AND 2012

	2013	2012
Assets		
Current Assets		
Cash and cash equivalents	$ 25,712,050	$ 25,756,594
Restricted cash	4,519,908	3,511,398
Short-term investments	1,203,559	1,089,172
Accounts receivable, less allowance ($20,453,000 in 2013 and $17,101,000 in 2012)		
Patients	29,957,753	32,367,012
Grants and other	3,702,524	2,977,504
	33,660,277	35,344,516
Inventories	3,586,821	3,305,079
Prepaid insurance and other expenses	1,603,096	1,525,890
Due from affiliates	189,379	195,978
Total Current Assets	70,475,090	70,728,627
Other Assets		
Under bond indenture agreements	34,218	30,070
Construction fund	--	661,338
	34,218	691,408
Property, Plant and Equipment		
Land	287,549	287,549
Buildings and improvements	97,137,417	95,206,351
Furniture, fixtures and equipment	187,642,399	185,958,291
Construction in progress (estimated additional cost to complete: 2013 - $13,000)	73,654	2,473,015
Accumulated depreciation	(240,510,083)	(232,453,154)
	44,630,936	51,472,052
Funds held in trust by others	44,960,039	42,218,163
Goodwill	1,813,567	1,813,567
CHEFA obligations issue expense, less amortization	282,676	321,666
Long-term investments	25,296,300	23,280,651
Board-designated endowment funds	3,193,664	2,974,503
Other investments	80,000	55,000
Loans and other receivables	359,375	521,906
Accrued interest and dividends receivable	13,743	22,017
	75,999,364	71,207,473
	$ 191,139,608	$ 194,099,560

The accompanying notes are an integral part of these financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS (CONTINUED)

SEPTEMBER 30, 2013 AND 2012

	2013	2012
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	$ 29,395,718	$ 37,244,812
Due to third-party reimbursement agencies	3,143,186	771,288
Current portion of CHEFA obligations	532,136	506,444
Current portion of notes payable	694,549	666,376
Total Current Liabilities	33,765,589	39,188,920
CHEFA Obligations - less current portion and discount	25,608,520	26,140,656
Notes Payable - less current portion	852,568	1,426,291
Other Noncurrent Liabilities	21,813,507	21,853,067
Net Assets		
Unrestricted	50,223,049	49,687,465
Temporarily restricted	8,409,794	7,645,420
Permanently restricted	47,752,075	45,010,199
Total Net Assets Excluding Noncontrolling Interests	106,384,918	102,343,084
Noncontrolling Interests	2,714,506	3,147,542
Total Net Assets	109,099,424	105,490,626
	$ 191,139,608	$ 194,099,560

The accompanying notes are an integral part of these financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Revenues		
Net revenues from services to patients	$259,397,257	$273,484,098
Provision for bad debts	(11,368,671)	(10,966,628)
Net patient service revenue less provision for bad debts	248,028,586	262,517,470
Investment related income	2,336,622	1,245,481
Other operating revenues	5,333,245	5,905,372
Services, sales and rental income	1,670,464	1,713,317
Unrestricted gifts and bequests	232,275	123,699
Net assets released from restrictions	5,419,591	5,609,005
	263,020,783	277,114,344
Expenses		
Salaries, wages and benefits	152,117,220	164,634,664
Supplies, utilities and other	101,697,631	100,249,125
Depreciation	8,996,581	9,421,603
Interest and amortization	1,125,827	1,237,849
	263,937,259	275,543,241
(Deficiency) Excess of Revenues over Expenses Before Net Unrealized Gains on Investments	(916,476)	1,571,103
Changes in Net Unrealized Gains on Investments	194,340	1,715,547
(Deficiency) Excess of Revenues Over Expenses	(722,136)	3,286,650
Less Excess of Revenues over Expenses Attributable to Noncontrolling Interests	(874,685)	(997,139)
(Deficiency) Excess of Revenues Over Expenses Attributable to Controlling Interest	(1,596,821)	2,289,511

The accompanying notes are an integral part of these financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Unrestricted Net Assets, Controlling Interest		
(Deficiency) excess of revenues over expenses	□ (1,596,821)	□ 2,289,511
Net assets released from restrictions used for purchase of property and e□uipment	19,654	134,036
Interest rate swap adjustment	1,209,256	(524,547)
Pension liability adjustments	903,495	366,769
Increase in Unrestricted Net Assets, Controlling Interest	535,584	2,265,769
Unrestricted Net Assets, Noncontrolling Interest		
Excess of revenues over expenses	874,685	997,139
Distributions and other	(1,307,721)	(1,031,774)
Decrease in Unrestricted Net Assets, Noncontrolling Interest	(433,036)	(34,635)
Temporarily Restricted Net Assets		
Gifts and be□uests	475,360	444,830
Income from investments	497,540	476,299
Net reali□ed and unreali□ed gains on investments	810,002	1,255,981
Grants	4,420,717	4,733,897
Net assets released from restrictions	(5,439,245)	(5,743,041)
Increase in Temporarily Restricted Net Assets	764,374	1,167,966
Permanently Restricted Net Assets		
Increase in funds held in trust by others	2,741,876	4,878,924
Increase in Permanently Restricted Net Assets	2,741,876	4,878,924
Increase in Net Assets	3,608,798	8,278,024
Net Assets - Beginning	105,490,626	97,212,602
Net Assets - End	□109,099,424	□105,490,626

The accompanying notes are an integral part of these financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Cash Flows from Operating Activities		
Change in net assets	$ 3,608,798	$ 8,278,024
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Provision for bad debts	11,368,671	10,966,628
Depreciation and amortization	9,035,571	9,529,602
Pension liability adjustments	(903,495)	(366,769)
Distributions to noncontrolling interests	1,307,721	1,031,774
Net realized and unrealized gains and change in fair value of funds held in trust by others	(4,648,320)	(6,959,218)
Restricted gifts, bequests and income from investments	(972,900)	(921,129)
Change in market value of interest rate swap	(1,209,256)	524,547
	17,586,790	22,083,459
Change in operating working capital, other than cash and cash equivalents and short-term investments:		
Patient accounts receivable, net	(8,959,412)	(13,749,013)
Grants and other receivables	(725,020)	1,406,813
Inventories	(281,742)	(46,317)
Prepaid insurance and other expenses	(77,206)	258,443
Accounts payable and accrued expenses	(7,849,094)	(3,385,387)
Due to third-party reimbursement agencies	2,371,898	3,405,769
Increase in other noncurrent liabilities	2,073,189	1,819,663
	(13,447,387)	(10,290,029)
Net Cash Provided by Operating Activities	4,139,403	11,793,430

The accompanying notes are an integral part of these financial statements.

GREATER WATERBURY HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Cash Flows from Investing Activities		
Increase in restricted cash	□ (1,008,510)	□ (9,473)
Cash received from affiliates	6,599	563
Cash paid to affiliates	--	(131,833)
Other assets	162,532	3,011,891
Additions to property, plant and e□uipment	(2,155,465)	(8,885,118)
Purchases of investments	(50,581,585)	(40,779,607)
Sales of investments	50,779,297	48,186,914
Net Cash (Used in) Provided by Investing Activities	(2,797,132)	1,393,337
Cash Flows from Financing Activities		
Restricted gifts, be□uests and income from investments	972,900	921,129
Distributions to noncontrolling interests	(1,307,721)	(1,031,774)
Net proceeds from issuance of debt	157,781	616,571
Principal payments on debt obligations	(1,209,775)	(1,095,933)
Net Cash Used in Financing Activities	(1,386,815)	(590,007)
Net (Decrease) Increase in Cash and Cash Equivalents	(44,544)	12,596,760
Cash and Cash Equivalents - Beginning	25,756,594	13,159,834
Cash and Cash Equivalents - End	□ 25,712,050	□ 25,756,594

Supplemental Cash Flow Information

Cash paid during the year for interest on borrowings was □1,300,968 and □1,396,529 for the years ended September 30, 2013 and 2012, respectively.

The accompanying notes are an integral part of these financial statements.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION

ORGANIZATION

Greater Waterbury Health Network, Inc. (the Corporation, Network or GWHN) was incorporated on September 27, 1984 as a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation's subsidiaries are The Waterbury Hospital (the Hospital), Greater Waterbury Health Services, Inc., Greater Waterbury Management Resources, Inc. (GWMRI), VNA Health at Home, Inc. (VNA), and the Children's Center of Greater Waterbury Health Network, Inc. (Children's Center). The accompanying financial statements also include Access Rehab Centers LLC (Access), Greater Waterbury Imaging Center Limited Partnership (GWIC), Imaging Partners, LLC, Alliance Medical Group, Inc. (AMG) and Cardiology Associates of Greater Waterbury, LLC to the extent of the Hospital's ownership interest in these affiliated entities.

On October 29, 2012, the Network signed a Letter of Intent to develop a Joint Venture relationship with Vanguard Health Systems, Inc. (Vanguard) of Nashville, TN, a network of for-profit hospitals. Under terms of the proposed Joint Venture, the two organizations would form a Limited Liability Company in which Vanguard would have an 80 percent ownership interest and GWHN would have a 20 percent interest. The Joint Venture would create a taxable, for-profit health system. The GWHN board selected Vanguard due to the company's unique ability to meet the long-term goals of the Greater Waterbury Health Network, Inc. Under the terms of the transaction, the new Joint Venture would be overseen by a 12-member board of directors, half of whom will be appointed by GWHN with Vanguard serving as manager of the Joint Venture. The transaction with Waterbury Hospital will allow it to expand its range of outpatient services to the communities it serves while also conducting extensive renovations and upgrades to the Hospital's main campus. The transaction will also allow the Hospital to continue to attract and maintain top-quality physicians. With the Letter of Intent, the two organizations have developed a Definitive Agreement for the Certificate of Need (CON) process, which will be necessary for the approval from the State of Connecticut Office of Health Care Access (OHCA) and the Office of the Attorney General. The transaction will also require approval from state and federal antitrust authorities.

On October 1, 2013, Tenet Healthcare Corporation (THC) completed its acquisition of Vanguard. THC is a leading health care services company, which through its subsidiaries operates 77 acute care hospitals, 173 outpatient centers and Conifer Health Solutions, a provider of business process solutions for health care providers serving more than 600 hospitals and other clients nationwide.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

During November 2010, the Hospital established a new limited liability company by the name of Cardiology Associates of Greater Waterbury, LLC (CAGW) to operate a cardiology practice. CAGW acquired the assets of Cardiology Associates of Waterbury (CAW) that were used by CAW physicians in the performance of their professional services.

The Hospital also acquired the assets of CAW that were used by CAW to perform diagnostic ancillary services. The Hospital converted these ancillary services to provider-based services, which are provided at a diagnostic center located near the Hospital. The goodwill recorded on the consolidated balance sheets relates to the purchase of CAW.

During June 2010, the Hospital entered into an arrangement with certain gastroenterology physician-members of the Hospital's medical staff to form Waterbury Gastroenterology Co-Management Company, LLC (GI Co-Management Company), a Connecticut limited liability company. This company was formed as a collaborative effort between the Hospital and the physicians for the purpose of improving the quality and efficiency of the gastroenterology service line at the Hospital. The Hospital's investment of $50,000 in the GI Co-Management Company is included in the Corporation's consolidated financial statements in long-term investments.

The Hospital entered into a members agreement, making it an equal member with St. Mary's Hospital, located in Waterbury, Connecticut, in a joint venture to form The Harold Leever Regional Cancer Center, Inc. (the Cancer Center). The Cancer Center is a Connecticut non-stock corporation exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The purpose of the joint venture is to develop, construct, own and operate the Cancer Center. Both member hospitals transferred the revenue and related expenses of their respective radiation oncology services to the Cancer Center in October 2002. Both member hospitals made working capital advances to the Cancer Center. The Cancer Center is not included in the Corporation's consolidated financial statements.

The Corporation's major accounting policies are as summarized below and in Note 2.

PRINCIPLES OF CONSOLIDATION

The consolidated financial statements include the accounts of the Corporation and the affiliated entities. Recognition has been given to noncontrolling interests in the affiliates which is reflected as a component of unrestricted net assets. All significant intercompany accounts and transactions are eliminated in consolidation.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated uncollectible accounts receivable for services to patients, and liabilities, including estimated net settlements with third-party reimbursement agencies and professional liabilities, and disclosure of contingent assets and contingent liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term. Actual results could differ from those estimates.

RECLASSIFICATIONS

Certain prior year amounts were reclassed to conform to the current year presentation.

REGULATORY MATTERS

The Hospital is required to file annual operating information with OHCA.

TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily restricted net assets are available to provide grant related services, free care, and educational seminars. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity or in funds held in trust by others.

DONOR RESTRICTED GIFTS

Unconditional promises to give cash are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises to give are received. Amortization of the discounts is included in gifts and bequests on the consolidated statements of operations and changes in net assets. Unconditional promises to give other assets are reported at fair value at the date the promise is received.

The gifts are reported as either temporarily or permanently restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

CASH AND CASH EQUIVALENTS

The Corporation considers all highly liquid investments with remaining maturities of three months or less at date of purchase to be cash equivalents. Cash and cash equivalents are held at a limited number of financial institutions and at times, the amounts on deposit exceed insured limits.

RESTRICTED CASH

The Hospital had letters of credit totaling $4.5 million and $3.5 million with banks available at September 30, 2013 and 2012, respectively, to support its self-insured workers' compensation program that were collateralized by certain investments held by the banks. As of September 30, 2013 and 2012, there were no borrowings on the letters of credit.

ACCOUNTS RECEIVABLE

Patient accounts receivable result from the health care services provided by the Corporation. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts.

The amount of the allowance for doubtful accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See Note 2 for additional information relative to net patient service revenue and third-party payor programs.

INVENTORIES

Inventories are stated at the lower of cost or market. The Corporation values its inventories using the first-in first-out method.

INVESTMENTS

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) and unrealized gains and losses are included in the (deficiency) excess of revenues over expenses unless the income or loss is restricted by donor or law.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

Unrealized gains and losses on investments related to permanently restricted net assets and certain temporarily restricted net assets are included in temporarily restricted net assets under State law which allows the Board of Trustees to appropriate as much of the net appreciation of investments as is prudent considering the Hospital's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions. Reference is made to Note 5.

OTHER ASSETS

Other assets include assets held by trustees under indenture agreements relating to financing activities with the State of Connecticut Health and Educational Facilities Authority. The portion of these amounts required for funding current liabilities is included in current assets.

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment are recorded at cost. The Corporation and its subsidiaries provide for depreciation of property, plant and equipment and amortization of assets recorded under capital leases using the straight-line method in amounts sufficient to amortize the cost of the assets over their estimated useful lives which range from 3 to 40 years.

Financial Accounting Standards Board (FASB) ASC 410-20, *Accounting for Asset Retirement Obligations* (ASC 410-20), provides guidance on accounting and reporting for obligations associated with the retirement of tangible long-lived assets and the associated asset retirement costs. Asset retirement obligations include, but are not limited to, certain types of environmental issues which are legally required to be remediated upon an asset's retirement as well as contractually required asset retirement obligations. ASC 410-20 provides clarifying guidance on conditional asset retirement obligations. Conditional asset retirement obligations are obligations whose settlement may be uncertain.

ASC 410-20's guidance requires such conditional asset retirement obligations to be estimated and recognized.

Conditional asset retirement obligations of $2,684,704 and $2,785,468 as of September 30, 2013 and 2012, respectively, are recorded in other noncurrent liabilities related to future asbestos remediation. During 2013 and 2012, there were no retirement obligations incurred or settled.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

GOODWILL

Goodwill, which has an indefinite life, is not amortized and is evaluated for impairment whenever events or business conditions indicate that the carrying values of such assets may not be fully recoverable.

IMPAIRMENT OF LONG-LIVED ASSETS

The Corporation records impairment losses on long-lived assets used in operations when events and circumstances indicate that the assets might be impaired and the undiscounted cash flows estimated to be generated by those assets are less than the carrying amounts of those assets. There were no impairment losses recorded in 2013 and 2012.

NONOPERATING GAINS

Activities, other than in connection with providing health care services, are considered to be nonoperating. Nonoperating gains consist primarily of income on invested funds, gains and losses on sales of securities, changes in unrestricted unrealized gains and losses and unrestricted gifts and bequests.

(DEFICIENCY) EXCESS OF REVENUES OVER EXPENSES

The consolidated statements of operations and changes in net assets include the (deficiency) excess of revenues over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from the (deficiency) excess of revenues over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), pension liability adjustments, and interest rate swap adjustments.

INCOME TAXES

The Corporation and its subsidiaries, with the exception of GWMRI, Access, GWIC, CAGW, and Imaging Partners LLC, are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c)(3) of the Internal Revenue Code. GWMRI has no current federal tax liability due to net operating losses since its date of incorporation. The Corporation is also exempt from state income tax.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

Access, GWIC, CAGW and Imaging Partners LLC are partnerships. For tax purposes, these partnerships are pass-through entities. Taxation does not occur at the partnership level. Accordingly, no provision for taxes is included. AMG is tax exempt under Section 501(c)(3) of the Code.

GWMRI has approximately $6,800,000 in net operating losses. This results in a deferred tax asset of $2,720,000 which is offset by a corresponding valuation allowance of the same amount.

Management has analyzed the tax positions taken and has concluded that as of September 30, 2013, there are no uncertain tax positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Corporation is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes the Corporation is no longer subject to income tax examinations prior to 2010.

MEDICAL MALPRACTICE AND WORKERS' COMPENSATION INSURANCE

The Hospital has a policy of self-insuring the deductible portion of its workers' compensation claims. The deductible limit is $500,000 and $400,000 per claim for the years ended September 30, 2013 and 2012, respectively. Management records its best estimate of losses as they occur. The accrued workers' compensation self-insurance liabilities of $9,996,921 and $9,871,633 at September 30, 2013 and 2012, respectively, have been discounted 2.25%.

Effective October 1, 2006, the Hospital obtained "claims-made" medical malpractice insurance coverage, through the Network, from Healthcare Alliance Insurance Company, Ltd. (HAIC). HAIC is a multi-provider captive insurance company domiciled in the Cayman Islands. The Network is a one third owner of the HAIC with two other local hospitals that each hold one third ownership. The Hospital's insurance coverage is $1,500,000 per occurrence and $5,000,000 in the aggregate. In addition to the coverage from HAIC, the Hospital recorded reserves of approximately $2,066,103 and $2,104,554 at September 30, 2013 and 2012, respectively, related to claims that were incurred subsequent to October 1, 2006, but not yet reported. These reserves were discounted at 2.25% at September 30, 2013 and 2012.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

The Hospital also obtains excess insurance coverage for professional and general liability, through the Network, from HAIC. These policies have limits of $25,000,000 per claim and $25,000,000 aggregate, in excess of the underlying limits in the primary layer, for both professional and general liability.

The Hospital also purchased a loss transfer insurance policy which provides $1,000,000 of coverage for each medical incident that was incurred between October 1, 2003 and October 1, 2006 and specifically reported to the insurance company on the effective date of the transfer policy (February 7, 2008) in addition to medical incidents incurred during the aforementioned period which are first reported after the effective date of the policy. This policy also provides $1,000,000 of coverage for general liability incurred but not reported claims that occurred after October 1, 2003 through October 1, 2006 and were first reported after the effective date of the policy.

The policy has annual aggregate limits of $4,500,000 for medical incidents and $3,000,000 for general liability cases with a combined $25,000,000 total limit for all policy years. These aggregate limits are eroded by claims previously paid by the Hospital or other insurance.

RETIREMENT BENEFIT PLANS

The Hospital maintains a defined benefit pension plan for eligible individuals and participates in two multi-employer pension plans that cover certain union employees. Reference is made to Note 9.

OTHER NONCURRENT LIABILITIES

Other noncurrent liabilities include the long-term portion of liabilities for medical malpractice, workers' compensation, retirement benefits, the interest rate swap, and conditional asset retirement obligations.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

RISKS AND UNCERTAINTIES

The Corporation invests in a variety of investment securities which are exposed to various risks, such as interest rate risk, financial market risk, currency risk and credit risk. Due to the level of risk associated with investment securities, coupled with the economic events, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the Corporation's September 30, 2013 financial statements, in addition to the funded status of its defined benefit pension plan.

NEW ACCOUNTING PRONOUNCEMENTS

BAD DEBTS

In July 2011, the FASB issued ASU 2011-07, *Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*, which requires certain health care entities to present the provision for bad debts associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense with enhanced footnote disclosures on the policies for recognizing revenue and assessing bad debts, in addition to qualitative and quantitative information about changes in the allowance for doubtful accounts. The pronouncement was adopted for the year ended September 30, 2013 and retrospectively applied to the year ended September 30, 2012. Refer to Note 2 for the additional disclosures required by ASU 2011-07. There was no material impact to the Corporation's consolidated financial statements aside from the required changes in presentation.

MULTI-EMPLOYER PENSION PLAN DISCLOSURES

ASU 2011-09, *Disclosures about an Employer's Participation in a Multi-Employer Plan*, became effective for the year ended September 30, 2013 and required additional disclosures regarding multi-employer pension plans. The Corporation has made these additional disclosures in Note 9. The adoption of this pronouncement had no material impact on the Corporation's consolidated financial statements.

NOTE 2 – REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE

The following summarizes net revenues from services to patients:

	2013	2012
Gross revenues from services to patients	$942,280,060	$971,551,590
Deductions (additions):		
Allowances	683,195,570	699,498,848
Regulatory	(312,767)	(1,431,356)
	682,882,803	698,067,492
Net revenues from services to patients	259,397,257	273,484,098
Provision for bad debts	11,368,671	10,966,628
Net patient service revenue less provision for bad debts	$248,028,586	$262,517,470

Patient accounts receivable and revenues are recorded when patient services are performed.

Amounts received from most payors are different from the established billing rates of the Hospital, and these differences are accounted for as allowances. Net revenues have been affected by State of Connecticut Disproportionate Share program in 2013 and 2012 which is reflected in the regulatory amounts in the table above.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. For the years ended September 30, 2013 and 2012, the Corporation recorded approximately ($2,400,000) and $2,066,000, respectively, as a (decrease) increase to net revenues from services to patients as changes in estimates related to third-party payor settlements and adjustments to accruals recorded in prior years.

During 2013 and 2012 approximately 37% and 43%, respectively, of net revenue from service to patients was received under the Medicare program, 16% and 11%, respectively, under the state Medicaid program, and 42% and 41%, respectively, from contracts with other third-parties.

NOTE 2 – REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE (CONTINUED)

Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Network. The State of Connecticut has announced reductions in the State's Disproportionate Share Reimbursement Program for the period from July 1, 2012 through June 30, 2015.

The significant concentrations of net accounts receivable for services to patients include 44% from Medicare, 13% from Medicaid, 24% from commercial insurance carriers and 19% from others at September 30, 2013 (47%, 13%, 25% and 15%, respectively, in 2012).

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. The Corporation believes that it is in compliance with all applicable laws and regulations. Cost reports for the Hospital, which serve as a basis for final settlement with government payors, have been settled by final settlement through 2009 for Medicare and 1995 for Medicaid. Other years remain open for settlement.

The Corporation has agreements with various Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the HMOs make fee-for-service payments to the Corporation for certain covered services based upon discounted fee schedules.

ALLOWANCE FOR DOUBTFUL ACCOUNTS

The Corporation's estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Corporation's collection efforts. The Corporation's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as the charges are recorded. On a monthly basis, the Corporation reviews its accounts receivable balances, the effectiveness of the Corporation's reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

- Revenue and volume trends by payor, particularly the self-pay components;
- Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;
- Various allowance coverage statistics.

NOTE 2 – REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE (CONTINUED)

The Corporation regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for doubtful accounts.

A summary of the Corporation's allowance for doubtful accounts activity for the years ended September 30, 2013 and 2012 is as follows:

	Balance at Beginning of Period	Additions Recorded in the Provision for Bad Debts	Accounts Written off, Net of Recoveries and Other	Balance at End of Period
Allowance for doubtful accounts:				
Year ended September 30, 2012	$ (15,162,000)	$ (10,966,628)	$ 9,027,628	$ (17,101,000)
Year ended September 30, 2013	$ (17,101,000)	$ (11,368,671)	$ 8,016,671	$ (20,453,000)

MEASURING CHARITY CARE

The Corporation accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Corporation. Essentially, these policies define charity services as those services for which no payment is possible. In assessing a patient's inability to pay, the Corporation utilizes the generally recognized Federal poverty income levels, but also includes certain cases where incurred charges are significant when compared to incomes and assets. These services are not included in net patient service revenues for financial reporting purposes.

Self-pay revenues are derived primarily from patients who do not have any form of health care coverage. The Corporation evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the Corporation's policy for charity care. The Corporation provides care without charge to certain patients that qualify under its charity care policy. For the years ended September 30, 2013 and 2012, the Corporation estimates that its costs of care provided under its charity care programs approximated $440,051 and $369,888, respectively.

NOTE 2 – REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE (CONTINUED)

The Corporation's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Corporation's gross charity care charges provided. The Corporation's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Corporation's charity care policy. To the extent the Corporation receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Corporation does not include these patients' charges in its cost of care provided under its charity care program. Additionally, the Corporation does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Corporation's policy not to pursue collection of amounts related to these patients.

ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS

The American Recovery and Reinvestment Act of 2009 (ARRA) included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are also available to providers that adopt, implement or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

Income from Medicare incentive payments is recognized as revenue after the Corporation has demonstrated that it complied with the meaningful use criteria over the entire applicable compliance period. The Corporation recognized revenue from Medicaid and Medicare for incentive payments after it adopted certified EHR technology. Medicaid incentive payments were $483,979 and $806,632 for the years ended September 30, 2013 and 2012, respectively. Medicare incentive payments were $1,939,299 and $2,585,732 for the years ended September 30, 2013 and 2012, respectively. Incentive payments are included in other operating revenues in the accompanying consolidated statements of operations and changes in net assets. Income from incentive payments is subject to retrospective adjustment as the incentive payments are calculated using Medicare cost report data that is subject to audit. Additionally, the Corporation's compliance with the meaningful use criteria is subject to audit by the federal government.

NOTE 2 – REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE (CONTINUED)

ICD-10 IMPLEMENTATION

The Corporation is subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically.

In January 2009, the Centers for Medicare and Medicaid Services (CMS) published its tenth revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the patient services provided by the Corporation will require much greater specificity when ICD-10 becomes effective on October 1, 2014.

The implementation of ICD-10 will require a significant investment in technology and training. The Corporation may experience delays in reimbursement while the Corporation and the payors from which it seeks reimbursement make the transition to ICD-10. If the Corporation fails to implement the new coding systems by the deadline, the Corporation will not be paid for services. Management is not able to reasonably estimate the overall financial statement impact of the Corporation's transition to ICD-10.

NOTE 3 - INVESTMENTS

The composition of investments, including funds held in escrow, is set forth in the following table. Investments are stated at fair value:

	2013		2012	
	Cost	Fair Value	Cost	Fair Value
Short-term investments:				
U.S. Treasury notes and other bonds	$ 62,002	$ 68,022	$ 87,136	$ 93,454
Marketable equity securities	202,843	295,936	231,802	344,945
Mutual funds	679,578	784,269	604,927	619,383
Certificates of deposit and money market funds	55,332	55,332	31,390	31,390
	$ 999,755	$ 1,203,559	$ 955,255	$ 1,089,172

NOTE 3 – INVESTMENTS (CONTINUED)

	2013		2012	
	Cost	Fair Value	Cost	Fair Value
Escrow funds for long-term debt:				
Cash and money market funds	$ 34,218	$ 34,218	$ 691,408	$ 691,408
	$ 34,218	$ 34,218	$ 691,408	$ 691,408
Investments of funds held in trust by others	$36,611,821	$44,960,039	$35,730,956	$42,218,163
Long-term investments and Board-designated endowment funds:				
Certificates of deposit and money market funds	$ 1,416,975	$ 1,416,975	$ 2,099,343	$ 2,099,343
Marketable equity securities	198,290	287,463	73,760	116,754
U.S. Government obligations	108,451	154,567	2,462,365	2,553,684
Corporate bonds	3,412,334	3,396,880	5,215,186	5,475,931
Annuity contract	100,000	182,882	100,000	178,878
Mutual funds	20,665,211	22,094,465	14,395,273	15,038,953
Alternative investments	--	--	164,929	37,758
	$25,901,261	$27,533,232	$24,510,856	$25,501,301

The Corporation had long-term investments in partnerships and joint ventures that were recorded at cost of $956,732 and $753,853 as of September 30, 2013 and 2012, respectively, as it was not practicable to estimate fair value. These investments are not included in the tables above.

Unrestricted investment income, including income on funds held in trust by others, and gains and (losses) are comprised of the following for the years ended September 30, 2013 and 2012:

	2013	2012
Income:		
Investment income	$ 1,434,520	$ 2,136,690
Realized gains (losses) on sales of investments	902,102	(891,209)
Changes in unrealized gains on investments	194,340	1,715,547
	$ 2,530,962	$ 2,961,028

NOTE 3 – INVESTMENTS (CONTINUED)

A summary of interest cost and investment income on borrowed funds held by the trustee under revenue bond indentures during the years ended September 30, 2013 and 2012 follows:

	2013	2012
Interest cost charged to operations	$ 1,017,986	$ 929,633
Investment income	$ 31	$ 233

NOTE 4 – FAIR VALUE MEASUREMENTS

The Corporation categorizes assets and liabilities for disclosure purposes based on whether the inputs used to determine their fair values are observable or unobservable. The Corporation utilizes a three-level fair value hierarchy that prioritizes the inputs used to measure assets at fair value. Level inputs are as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Corporation has the ability to access on the reporting date.

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset.

Level 3 – Inputs that are unobservable for the asset or liability.

The fair values of Level 1 securities were determined through quoted market prices, while fair values of Level 2 securities were determined primarily through prices obtained from third party pricing sources, where quoted market prices for such securities are not available. The fair values of Level 3 securities were determined primarily through information obtained from the relevant counterparties for such assets and liabilities, as information on which these fair values are based is generally not readily available in the market.

The fair value of the interest rate swap was determined by the counterparty based on an estimate of the net present value of the expected cash flows using relevant mid-market data inputs and based on the assumptions of no unusual market conditions or forced liquidation.

NOTE 4 – FAIR VALUE MEASUREMENTS (CONTINUED)

Reference is made to Note 1 regarding the determination of the fair value of private equity and commingled funds classified as alternative investments.

The following table summarizes fair value measurements, by level, at September 30, 2013, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 33,532,557	$ --	$ --	$ 33,532,557
Common stock-Insurance	93,309	--	--	93,309
Mutual funds:				
U.S. large cap	35,292,087	--	--	35,292,087
U.S. mid cap	3,460,785	--	--	3,460,785
U.S. small cap	3,034,881	--	--	3,034,881
International developed	6,499,479	--	--	6,499,479
Emerging markets	2,705,380	--	--	2,705,380
Fixed income securities:				
Investment grade taxable	2,773,252	11,202,070	--	13,975,322
International developed bonds	1,237	719,184	--	720,421
Global high yield taxable	261,841	2,027,557	--	2,289,398
Real estate investment trusts	1,973,202	--	--	1,973,202
Other	101,506	284,678	--	386,184
Total investments at fair value	$ 89,729,516	$ 14,233,489	$ --	$ 103,963,005
Liabilities:				
Interest rate swap	$ --	$ 1,729,706	$ --	$ 1,729,706

NOTE 4 – FAIR VALUE MEASUREMENTS (CONTINUED)

For the year ended September 30, 2013, the changes in fair value of assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	Long-term Investments
Balance, as of September 30, 2012	$ 37,758
Net realized and unrealized losses on investments	(27)
Sales	(37,731)
Balance, as of September 30, 2013	$ --

The following table summarizes fair value measurements, by level, at September 30, 2012, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 34,288,297	$ --	$ --	$ 34,288,297
Common stock-Insurance	64,739	--	--	64,739
Mutual funds:				
U.S. large cap	23,242,440	--	--	23,242,440
U.S. mid cap	2,972,585	--	--	2,972,585
U.S. small cap	2,025,227	--	--	2,025,227
International developed	7,683,020	--	--	7,683,020
Emerging markets	2,394,768	--	--	2,394,768
Bonds	345,802	--	--	345,802
Fixed income securities:				
Investment grade taxable	2,934,382	10,423,958	--	13,358,340
International developed bonds	--	2,559,686	--	2,559,686
Global high yield taxable	399,340	2,977,811	--	3,377,151
U.S. Government obligations	3,661,481	--	--	3,661,481
Mortgage backed securities	--	873,732	--	873,732

NOTE 4 – FAIR VALUE MEASUREMENTS (CONTINUED)

	Level 1	Level 2	Level 3	Total
Other investments:				
Commingled funds real estate	$ --	$ --	$ 37,758	$ 37,758
Real estate investment trusts	1,844,510	--	--	1,844,510
Other	38,500	--	--	38,500
Total investments at fair value	$ 81,895,091	$ 16,835,187	$ 37,758	$ 98,768,036
Liabilities:				
Interest rate swap	$ --	$ 2,938,962	$ --	$ 2,938,962

For the year ended September 30, 2012, the changes in fair value of assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	Long-term Investments
Balance, as of September 30, 2011	$ 10,433,613
Net realized and unrealized gains on investments	832,476
Sales	(11,228,331)
Balance, as of September 30, 2012	$ 37,758

NOTE 5 – RESTRICTED ENDOWMENTS

The Hospital's endowments consist of donor-restricted endowment funds and Board designated endowment funds. Net assets associated with endowment funds are classified and reported based on donor-imposed restrictions.

NOTE 5 – RESTRICTED ENDOWMENTS (CONTINUED)

The Hospital's Board of Trustees has interpreted the Connecticut Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and, if applicable (c) accumulations to the permanent endowment made in accordance with the related gift's donor instructions. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard for expenditure as proscribed by UPMIFA. In accordance with UPMIFA, the Hospital considers the following factors in making determinations to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund
(2) The purposes of the Hospital and the donor-restricted endowment fund
(3) General economic conditions
(4) The possible effect of inflation and deflation
(5) The expected total return from income and the appreciation of investments
(6) Other resources of the Hospital
(7) The investment policies of the Hospital

RETURN OBJECTIVES AND RISK PARAMETERS

For the permanently restricted endowment funds, the bank, acting in its capacity as trustee, determines and directs the investment policy and asset allocation. For the unrestricted and temporarily restricted endowment funds, the Hospital's Board of Trustees has adopted investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. The Hospital expects these endowment funds, over time, to provide an average rate of return that exceeds the rate of inflation by 3.5% annually. Actual returns in any given year may vary from this amount.

NOTE 5 – RESTRICTED ENDOWMENTS (CONTINUED)

STRATEGIES EMPLOYED FOR ACHIEVING OBJECTIVES

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

SPENDING POLICY AND HOW THE INVESTMENT OBJECTIVES RELATE TO SPENDING POLICY

The Hospital has a policy of evaluating the spending decisions for each endowment fund based upon the intentions of the donors and specific contractual agreements. In determining the annual amount to be spent, the Hospital considers the long-term expected return on its endowment. The spending policy is designed to limit spending to the expected long-term real rate of return. The annual distribution from the endowment funds is expected to be contained within a range of 4-6% of the trusts' market value. This is consistent with the Hospital's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 7,446,152	$47,752,075	$55,198,227
Board-designated endowment funds	3,193,664	--	--	3,193,664
Total funds	$ 3,193,664	$ 7,446,152	$47,752,075	$58,391,891

NOTE 5 – RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 2,974,503	$ 6,806,683	$45,010,199	$54,791,385
Investment return:				
Investment income	72,896	238,568	--	311,464
Net appreciation	277,353	829,688	2,741,876	3,848,917
Total investment return	350,249	1,068,256	2,741,876	4,160,381
Appropriation of endowment assets for expenditure	(131,088)	(428,787)	--	(559,875)
Endowment net assets, ending balance	$ 3,193,664	$ 7,446,152	$47,752,075	$58,391,891

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 6,806,683	$45,010,199	$51,816,882
Board-designated endowment funds	2,974,503	--	--	2,974,503
Total funds	$ 2,974,503	$ 6,806,683	$45,010,199	$54,791,385

NOTE 5 – RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 2,615,009	$ 5,696,591	$40,131,275	$48,442,875
Investment return:				
Investment income	72,000	259,851	--	331,851
Net appreciation	406,963	1,266,934	4,878,924	6,552,821
Total investment return	478,963	1,526,785	4,878,924	6,884,672
Appropriation of endowment assets for expenditure	(119,469)	(416,693)	--	(536,162)
Endowment net assets, ending balance	$ 2,974,503	$ 6,806,683	$45,010,199	$54,791,385

NOTE 6 – TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Permanently restricted net assets at September 30, 2013 and 2012, are restricted amounts which are to be held in perpetuity, the income from which is expendable to provide free care, scholarships for the children of the Hospital's employees, and for the operations of the Hospital. Also included in permanently restricted net assets are funds held in trust by others. The Hospital is the restricted income beneficiary of funds held in trust by others. The total trust assets, as reported by the trustee, had an aggregate fair value at September 30, 2013 and 2012 of $44,960,039 and $42,218,163, respectively. Income of $1,896,981 and $1,759,075 earned on these assets for the years ended September 30, 2013 and 2012, respectively, is included in investment income.

Temporarily restricted net assets are available to provide psychiatric services, free care and educational seminars.

During 2013, net assets were released from donor restrictions by incurring expenses which satisfied the restricted purposes in providing grant related services, free care, and various miscellaneous services in the amounts of $4,420,718, $657,252 and $341,621, respectively in 2013 and $4,733,897, $625,195, and $249,913, respectively in 2012. In addition, $19,654 and $134,036 were released for the purchase of property and equipment in 2013 and 2012, respectively.

NOTE 7 - DEBT

SERIES C AND D BOND FINANCING

In December 2010, the Hospital refinanced its Series C bond financing and financed an additional $8,000,000 for various capital projects to be completed over a two year period. The par amount of the new Series D debt was $25,918,000 and interest is variable at the interest rate that is equal to the product of (i) sixty-eight percent (68%) and (ii) the sum of the LIBOR Rate and three hundred basis points (2.16% at September 30, 2013). The new bonds require monthly principal and interest payments, based upon a 10 year amortization schedule, from 2011 through 2020 with the remaining principal balance due in 2020.

The terms of the bonds provide for, among other things, a pledge of gross receipts of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and provide for covenants regarding the Hospital's debt service coverage ratios, minimum levels of cash on hand, sale and lease of assets and other covenants similar in financings of this type.

In connection with this refinancing, the Hospital entered into an interest rate swap with a bank which allowed it to convert its variable interest rate liability to a fixed interest rate liability of 4.475% without changing the structure of the underlying debt.

The Hospital uses the interest rate swap agreement to manage interest rate risk associated with its outstanding debt. At September 30, 2013 and 2012, the notional value of outstanding interest rate swap was $24,755,656 and $25,207,100, respectively.

The Hospital recognizes the fair value of its interest rate swap in the consolidated balance sheet as a liability, recorded in other noncurrent liabilities. At September 30, 2013 and 2012, the fair value of interest rate swap was in a liability position of $1,729,706 and $2,938,962, respectively.

The Hospital designated its interest rate swap as a cash flow hedge for accounting purposes, and accordingly defers gains or losses associated with the swap in net assets.

CHILDREN'S CENTER SERIES D BOND FINANCING

On August 1, 2000, the Children's Center of Greater Waterbury Health Network, Inc. entered into Series D financing arrangements with CHEFA under a Master Indenture for the financing of the construction of a new child care center building. To finance the above, CHEFA sold $1,945,000 of Series D revenue bonds.

NOTE 7 – DEBT (CONTINUED)

Under the terms of the financing arrangements between the Children's Center and CHEFA, the proceeds of the revenue bonds were loaned to the Children's Center. Pursuant to the loan agreement, the Children's Center was obligated to provide amounts which will be sufficient to enable CHEFA to pay the principal of and interest on the proceeds of the Series D Bonds.

Concurrently with the issuance and delivery of the Series D Bonds, the Children's Center and U.S. Bank NA, as Trustee, entered into the Master Indenture and Supplemental Master Indentures Numbers 1 and 2, pursuant to which the Children's Center was obligated to pay the amount due under the loan agreement with CHEFA. The Master Indenture and Supplemental Master Indentures provide for, among other things, the establishment and maintenance of a Debt Service Reserve Fund (which has been funded by the State of Connecticut as discussed below) and a pledge of the gross receipts, as defined, of the Children's Center, restriction on the incurrence of certain indebtedness of the Children's Center and covenants regarding the Children's Center's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type.

CHILDREN'S CENTER SERIES 2011 BONDS

In August 2011, CHEFA sold $28,840,000 of Series 2011 revenue bonds, the proceeds of which were used to redeem a number of bond series, including the Children's Center Series D bonds described above. As a result of the sale of the Series 2011 bonds, the Children's Center's loan with CHEFA was refinanced and reduced from $1,560,000 to $1,505,000. The Series 2011 bonds mature serially from 2012 through 2030, with interest rates ranging from 1% to 5%.

Pursuant to Public Act No. 97-259 (the School Readiness Act), the State of Connecticut has encouraged the development of a network of school readiness programs that meet the standards developed by the State Department of Education. To encourage such development, the School Readiness Act established, among other things, the Child Care Facilities Program to finance low interest loans for the purpose of new construction of child care centers. The State of Connecticut, acting through the Commissioner of the Department of Social Services, may allow actual debt service on such loans and a debt service reserve fund to be paid by the State of Connecticut provided that such debt service terms are determined by the Commissioner to be reasonable. The State of Connecticut has funded the debt service reserve fund and has agreed to fund, subject to available appropriations, 83.6% of the debt service on the Series 2011 Bonds and to replenish any deficiencies in the debt service reserve fund. During 2013 and 2012, the total debt service funded by the State of Connecticut was $103,351 and $109,009, respectively.

NOTE 7 – DEBT (CONTINUED)

Future minimum payments by year and in the aggregate, subject to early redemption provisions discussed above, under the CHEFA bonds are as follows at September 30, 2013:

2014	$ 532,136
2015	548,776
2016	576,408
2017	600,080
2018	629,832
Aggregate thereafter	23,253,424
	$ 26,140,656

Access has a $250,000 line of credit with a bank. There were no borrowings under this line of credit at September 30, 2013 and 2012.

In April 2005, the VNA established a $500,000 line of credit with Webster Financial Advisors. The line of credit expired on November 1, 2013 and VNA is currently in the process of renewing the line. The interest rate at June 30, 2013 and 2012 was 5% and 4.25%, respectively. The line of credit is secured by the VNA's investments held by Webster Financial Advisors and a first lien on all business assets located at 27 Siemon Company Drive, Watertown, Connecticut. There were no advances on the line of credit at September 30, 2013 and 2012.

AMG had a capital lease for equipment that called for monthly payments of $1,485 through April 2013 and was secured by the equipment. The balance of the capital lease liability was $0 at September 30, 2013 and $10,054 at September 30, 2012.

AMG has a capital lease for equipment that calls for monthly payments of $593 through January 2014 and is secured by the equipment. The balance of the capital lease liability was $2,858 at September 30, 2013 and $9,037 at September 30, 2012.

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $353 through March 2015 and is secured by the equipment. The balance of the capital lease liability was $5,877 at September 30, 2013 and $9,445 at September 30, 2012.

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $447 through May 2015 and is secured by the equipment. The balance of the capital lease liability was $8,687 at September 30, 2013 and $13,095 at September 30, 2012.

NOTE 7 – DEBT (CONTINUED)

The Hospital entered into a capital lease for equipment during 2011. The lease calls for equal monthly payments of $20,885 through May 2016 and is secured by the equipment. The balance of the capital lease liability was $609,435 at September 30, 2013 and $835,685 at September 30, 2012.

The Hospital entered into a capital lease for equipment during 2011. The lease called for equal monthly payments of $14,031 through July 2013 and was secured by the equipment. The balance of the capital lease liability was $0 at September 30, 2013 and $137,403 at September 30, 2012.

AMG entered into a term note during 2010 at an interest rate of 9.8%. The note calls for monthly payments of $13,216 through November 2014 and is secured by the assets of AMG. The balance of the term note liability was $173,794 at September 30, 2013 and $307,277 at September 30, 2012.

AMG assumed a note payable during 2009 for the fit-up of office space. The original amount of the note was $320,000 and is repayable in installments of principal plus interest at 7.50% totaling $4,908 per month through January 2014. In addition, this note calls for a final payment of principal and interest of $113,981 in February 2014. The balance of this note was $129,815 at September 30, 2013 and $177,038 at September 30, 2012.

The Hospital entered into a capital lease for equipment during 2012. The lease calls for equal monthly payments of $11,469 through August 2017 and is secured by the equipment. The balance of the capital lease liability was $495,826 at September 30, 2013 and $593,633 at September 30, 2012.

The Hospital entered into a capital lease for equipment during 2013. The lease calls for equal monthly payments of $4,779 through November 2015. The balance of capital lease liability was $120,826 at September 30, 2013.

NOTE 7 – DEBT (CONTINUED)

Future minimum payments by year and in the aggregate for all non-CHEFA obligations were as follows at September 30, 2013:

2014	$ 694,549
2015	448,424
2016	280,624
2017	123,520
	$ 1,547,117

The fair value of the debt, using the discounted cash flow analyses, was approximately $29,406,000 and $30,750,000 at September 30, 2013 and 2012, respectively.

NOTE 8 – RENTAL EXPENSE AND LEASE COMMITMENTS

The Hospital, VNA and GWMRI have entered into operating leases for office space and office equipment. Rental expense for the years ended September 30, 2013 and 2012 was $4,792,560 and $4,710,265, respectively. The minimum rental commitments under all noncancellable operating leases with initial or remaining terms of more than one year are as follows:

2014	$ 4,403,351
2015	3,592,196
2016	3,271,507
2017	2,479,208
2018	27,036
Thereafter	201,566
	$ 13,974,864

NOTE 9 – EMPLOYEE BENEFIT PLANS

The Hospital has a noncontributory defined benefit cash balance plan (the Plan). Under the Plan, each participant who elected to transfer their balances to the Plan from the former defined contribution plan receives a credit of 6% of compensation allocated to their cash balance accounts. All other participants receive a 3% credit. Additionally, each participant receives an interest credit to their cash balance account based on the yield to maturity on three-year treasury bills. The Plan covers substantially all non-union employees age 21 and older with one year of service. It is the Hospital's policy to make contributions to the Plan sufficient to meet the minimum funding requirements of applicable laws and regulations.

Following is a summary of the Plan's funded status using the measurement dates of September 30, 2013 and 2012 and amounts recognized in the Corporation's consolidated financial statements.

	2013	2012
Change in benefit obligation		
Benefit obligation beginning of year	$ (37,888,825)	$ (37,373,483)
Service cost	(1,702,273)	(1,220,226)
Interest cost	(1,154,537)	(1,798,078)
Actuarial gain (loss)	2,126,771	(443,054)
Benefits paid	3,056,653	2,946,016
Benefit obligation, end of year	$ (35,562,211)	$ (37,888,825)
Change in plan assets		
Fair value of plan assets, beginning of year	$ 28,843,113	$ 26,540,513
Actual return on plan assets	253,055	2,716,897
Employer contributions	1,162,156	2,531,719
Benefits paid	(3,056,653)	(2,946,016)
Fair value of plan assets, end of year	$ 27,201,671	$ 28,843,113
Funded status	$ (8,360,540)	$ (9,045,712)
Accrued pension liability	$ (8,360,540)	$ (9,045,712)

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

	2013	2012
Components of net periodic pension cost		
Service cost	$ 1,702,273	$ 1,220,226
Interest cost	1,154,537	1,798,078
Expected return on plan assets	(2,483,658)	(2,566,157)
Amortization of actuarial loss	971,872	623,556
Amortization of prior service cost	35,455	35,527
Net periodic pension cost	$ 1,380,479	$ 1,111,230
Accumulated benefit obligation	$ 34,675,898	$ 36,832,025

Included in unrestricted net assets are the following amounts that have not yet been recognized in net periodic cost:

	2013	2012
Unrecognized prior service cost	$ (156,531)	$ (191,986)
Unrecognized actuarial losses	(14,772,799)	(15,640,839)
Benefit obligation, end of year	$ (14,929,330)	$ (15,832,825)

Changes in benefit obligations recognized in unrestricted net assets include:

	2013	2012
Current year actuarial losses	$ (103,832)	$ (292,314)
Amortization of prior service cost	35,455	35,527
Amortization of net loss	971,872	623,556
	$ 903,495	$ 366,769

The prior service cost and actuarial losses included in unrestricted net assets and expected to be recognized in net periodic cost during the year ending September 30, 2014 are $35,455 and $816,016, respectively.

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

ASSUMPTIONS

The weighted-average assumptions used to determine benefit obligations at September 30 are as follows:

	2013	2012
Discount rate	3.99%	3.17%
Expected return on plan assets	8.00%	8.00%
Rate of compensation increase	2% for 3 year select period, 3% ultimate	2% for 4 year select period, 3% ultimate

The weighted-average assumptions used to determine net periodic benefit cost for years ended September 30 are as follows:

	2013	2012
Discount rate	3.17%	5.07%
Expected return on assets	8.00%	8.00%
Rate of compensation increase	2% for 4 year select period, 3% ultimate	2% for 5 year select period, 3% ultimate

EXPECTED LONG-TERM RETURN ON PLAN ASSETS

To develop the expected long-term rate of return on assets assumptions, the Hospital considered the historical returns and the future expectations of returns for each asset class, as well as target asset allocations of the pension portfolio. This resulted in the selection of the 8.0% long-term rate of return.

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

INVESTMENT POLICY

The Plan's weighted-average asset allocation at September 30, 2013, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
Global defense e□uity unhedged	10□	10□	5□ - 15□
Custom fixed income	90□	90□	85□ - 95□

The Plan's weighted-average asset allocation at September 30, 2012, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
E□uity securities	44□	45□	40□ - 50□
Debt securities	33□	35□	25□ - 45□
Multi-strategy hedge fund of funds	20□	20□	15□ - 25□
Cash and cash e□uivalents	3□		

The Pension Committee of the Board of Trustees (the Committee) is responsible for employee benefit program policies with respect to plan assets and the retention of □ualified managers, consultants and trustee□custodians. The purpose of the Committee is to ensure the Plan assets accumulate monies re□uired to meet the anticipated benefit payments of the Plan; contributions are made by the Hospital on a basis determined by the Plan's actuary to be ade□uate to fund the benefits. The investment objective of the Committee is to maximi□e total return after inflation within the limits of prudent risk taking by diversifying across asset classes and multiple managers. The Committee has established an asset allocation policy that sets a target and range for each asset class, as shown in the table above.

CONTRIBUTIONS

The Hospital expects to make □1,500,000 in contributions to the Plan in 2014.

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

ESTIMATED FUTURE BENEFIT PAYMENTS

The following benefit payments which reflect expected future service are expected to be paid as follows:

2014	$ 3,702,000
2015	3,025,000
2016	3,414,000
2017	3,289,000
2018	3,512,000
2019-2023	15,898,000
	$ 32,840,000

As required by ASC 820, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

The following tables set forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2013.

	Level 1	Level 2	Level 3	Total
Commingled funds and private equity	$ --	$ --	$27,201,671	$27,201,671

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

The following tables set forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2012.

	Level 1	Level 2	Level 3	Total
Equities	$ 1,450,511	$ --	$ --	$ 1,450,511
Commingled funds and private equity	--	--	19,307,214	19,307,214
U.S. Government obligations	4,463,951	--	--	4,463,951
Corporate bonds	--	3,210,511	--	3,210,511
Distribution receivable	363,345	--	--	363,345
Interest and dividends	47,581	--	--	47,581
	$ 6,325,388	$ 3,210,511	$ 19,307,214	$ 28,843,113

The following is a reconciliation of Level 3 assets, collective investments and common trust funds, for which significant unobservable inputs were used to determine fair value:

	2013	2012
Balance as of September 30	$ 19,307,214	$ 17,038,042
Change in unrealized (depreciation) appreciation	(487,433)	2,362,257
Purchases	52,316,941	7,446,351
Sales	(43,935,051)	(7,539,436)
Balance as of September 30	$ 27,201,671	$ 19,307,214

OTHER BENEFIT PLANS

The Hospital participates in multi-employer pension plans that cover substantially all union employees. Contributions to the plans are based upon a percentage of each participant's total salary. The risks of participating in these multi-employer plans are different from single-employer plans in the following aspects:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of another participating employer.

- If a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers.

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

- If the Hospital chose to stop participating in the multi-employer plans, the Hospital may be required to pay those plans an amount based on the underfunded status of the plans, referred to as a withdrawal liability.

The following table presents the Hospital's participation in these plans as of and for the years ended September 30, 2013 and 2012.

Pension Trust Fund	Pension Plan Employer Identification Number	Pension Protection Act ("PPA") Certified Zone Status[1] 2013	Pension Protection Act ("PPA") Certified Zone Status[1] 2012	FIP/RP Status Pending/ Implemented[2]	Contributions 2013	Contributions 2012	Surcharge Imposed	Expiration Date of Collection Bargaining Agreement[3]
Connecticut Health Care Associates Pension Fund	06-1313462	Green	Green	N/A	$ 2,077,612	$ 2,230,433	No	September 30, 2013
New England Health Care Employees Pension Fund	22-3071963	Green	Green	N/A	783,235	865,646	No	February 29, 2016
				Total Contributions:	$2,860,847	$3,096,079		

[1] The most recent PPA zone status available in 2013 and 2012 is for the plan's year-ending during 2012 and 2011, respectively. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.

[2] The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented.

[3] Lists the expiration dates of the collective-bargaining agreements to which the plans are subject.

During the years ended September 30, 2013 and 2012, the Hospital's contributions to the Connecticut Health Care Associates Pension Plan represented approximately 96% of the total contributions made to the plan by all participating employers.

During the years ended September 30, 2013 and 2012, the Hospital's contributions to the New England Health Care Employees Pension Plan represented 3% of the total contributions made to the plan by all participating employers.

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. The Hospital has explored the costs to withdraw from the Connecticut Health Care Associates (CHCA) Pension Plan in the event that the Hospital enters into a joint venture (Note 1). As of September 30, 2013, it is estimated a withdrawal liability to exit this plan would be $17,200,000. It is expected that CHCA will likewise withdraw from the pension plan making a total withdrawal liability for the Hospital of approximately $27,700,000. Management expects that the costs to withdraw from the plan will be funded by the proceeds from the transaction and payable over time at the rate of $2,400,000 per annum.

NOTE 9 – EMPLOYEE BENEFIT PLANS (CONTINUED)

The VNA has a defined contribution pension plan which covers substantially all full-time employees, in addition to a non-contributory discretionary pension plan for which contributions are made annually at the discretion of the VNA's Board of Directors.

In addition, the Hospital has a supplemental employee retirement plan for certain executives. The plan provides for a total benefit and is partially funded. As of September 30, 2013 and 2012, liabilities of $240,869 and $152,244, respectively, have been reflected in the consolidated balance sheets.

As noted above, the Hospital also has a noncontributory defined benefit cash balance plan covering substantially all non-union employees age 21 and older with one year of service. Total pension expense, relating to this plan, charged to operations during the years ended September 30, 2013 and 2012 was $1,380,479 and $1,111,230, respectively.

NOTE 10 – SELF INSURANCE CLAIMS

There have been medical malpractice and workers' compensation claims that fall within the Corporation's partially self-insured programs, which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2013 that may result in the assertion of claims. Corporation management has accrued its best estimate of these contingent losses. Other claims may be asserted arising from services provided to patients or workers' compensation incidents in the past. Corporation management has provided reserves for these contingent liabilities.

NOTE 11 – COMMITMENTS AND CONTINGENCIES

The Corporation is a party to various lawsuits incidental to its business.

NOTE 12 – DUE FROM (TO) AFFILIATES

The amounts due from affiliates of □189,379 and □195,978 at September 30, 2013 and 2012, respectively, represent receivables from and (payables) to affiliates that do not eliminate in consolidation. These balances are comprised of the following:

	2013	2012
Greater Waterbury Management Resources	□ 197,863	□ 204,462
Alliance Medical Group	(9,984)	(9,984)
GI Co-Management Company	1,500	1,500
	□ 189,379	□ 195,978

NOTE 13 – FUNCTIONAL EXPENSES

The Corporation provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows:

	2013	2012
Health care services	□198,516,495	□207,955,761
General and administrative	65,059,933	67,298,685
Fundraising	360,831	288,795
	□263,937,259	□275,543,241

NOTE 14 – SUBSEQUENT EVENTS

The Network evaluates the impact of subse□uent events, events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date or for disclosure in the notes to the financial statements. The Network evaluated events occurring subse□uent to September 30, 2013 through January 10, 2014, the date on which the accompanying consolidated financial statements were available to be issued. During this period, there were no subse□uent events that re□uired recognition in the consolidated financial statements.

SCHEDULE 3.07

RECENT ACTIVITIES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.09

EQUIPMENT DEPRECIATION SCHEDULE

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.10

TITLE TO ASSETS

See attached UCC report.

See Schedule 3.11(a).

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR:	Marisol Skibicki at 561
REF. NO:	3274-1135
DATE:	06/30/16
INDEX DATE:	06/17/16
IRS INDEX DATE:	06/23/16
DRC REF. NO:	506518

REGARDING: THE WATERBURY HOSPITAL

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There are 22 presently effective records under the debtor name.

[**X**] See attached

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

WATERBURY HOSPITAL

1) 2419467
   2419587-Office Correction
   2419604-Office Correction
2) 2828623
3) 2791044
4) 3067900
5) 2791045
6) 3067884
7) 3087067
8) 3094137
9) 2852974
10) 2890181
11) 2912417
12) 2951331
13) 2969025
14) 3015083
15) 3028590
16) 3079617
17) 3025143
18) 3047052
19) 3074593
20) 3097903
21) 3113081
22) 3121843

[redacted]

FILING #0002419467 PG 01 OF 26 VOL U-00345
FILED 10/11/2006 11:00 AM PAGE 01538
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]

B. SEND ACKNOWLEDGMENT TO: (Name and Address) LR1

Corporation Service Company
801 ADLAI STEVENSON DRIVE
Springfield, IL 62703

Waterbury Hospital
513370-1

11:00

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (1a or 1b) - do not abbreviate or combine names

1a. ORGANIZATION'S NAME: Waterbury Hospital The

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 Robbins St.	Waterbury	CT	06721	USA

1d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		CORP	CT	0267808 ☐ NONE

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (2a or 2b) - do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ NONE

3. SECURED PARTY'S NAME (or NAME of TOTAL ASSIGNEE of ASSIGNOR S/P) - insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: Siemens Financial Services, Inc.

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
170 Wood Avenue South	Iselin	NJ	08830	USA

4. This FINANCING STATEMENT covers the following collateral:

See Attached Exhibits for description of collateral. Schedule No. 319-000975-002.
Exhibit A - Equipment
Exhibit B - Chattel Paper

5. ALTERNATIVE DESIGNATION [if applicable]: ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA 319-0050975-002

CT-Secretary Of State

25pgs

FILING OFFICE COPY — UCC FINANCING STATEMENT (FORM UCC1) (REV. 05/22/02)

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

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FILED 10/11/2006 11:00 AM PAGE 01539
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EXHIBIT A

DESCRIPTION OF EQUIPMENT

Description:	**Approximate Total Cost:**
As shown on Exhibit B to the Performance Service Agreement between The Waterbury Hospital and Siemens Building Technologies, Inc. dated July 14, 2006.	$4,822,201.00

Exhibit A

Article 1: Scope of FIM Work

FIM#-1 Lighting and Lighting Controls

- Provide and install all lighting equipment and lighting occupancy sensors described in Exhibit D, "Lighting Retrofit Tables".
- The following table summarizes the lighting and control quantities by building:

Table 1.1 – Lighting Retrofits

Building	Quantity of Lighting Fixtures Retrofitted /Replaced	Quantity of Fixtures Controlled by Occupancy Sensors
Main Hospital	992	2,242
Merriman Hall	268	319
Children's Center	91	166
TOTALS	1,351	2,727

The scope of work *shall not include* the following;

- Repairing faulty ground wiring.
- Replacing retrofitted fixtures that have concealed damage.

FIM#-2 Install Variable Frequency Drives & Premium Efficiency Motors

- Provide and install Variable Frequency Drives (VFDs) for the motors listed in Table 1.2 below:

Table 1.2 – VFD Retrofits

Equipment ID	Location	Function	HP
P-1	Boiler House Basement	Boiler Feedwater Pump	30
P-2	Boiler House Basement	Boiler Feedwater Pump	30
P-3	Boiler House Basement	Boiler Feedwater Pump	30
CHWP-3	Chiller Room	Secondary CHW Pump	150
CHWP-4	Chiller Room	Secondary CHW Pump	150
RHP-7	Pomeroy MER-3	Pomeroy B-9th Flr Reheat Pumps	5
RHP-8	Pomeroy MER-3	Pomeroy B-9th Flr Reheat Pumps	5
BL-7A (SF)	Pomeroy MER-2	OR's, 1, 2, 3, 5 & 12	20
BL-9A (SF)	Pomeroy MER-2	OR's 4, 6-11, Cystology & Offices	20
BL-11 (SF)	Pomeroy MER-2	OR Hallways & Outer Offices	10
BL-12 (SF)	Pomeroy MER-2	OR Recovery Area	10

- Mount the VFD's either floor or wall mounted and located as close as possible to the associated pump or fan.
- Installation and mounting locations, including necessary clearances, shall meet the requirements of the National Electric Code, latest edition.
- Install control wiring to VFD's.
- Connect motors to new VFD and disconnect existing electrical motor starters from MCC.
- Startup of VFD's.
- Provide and install new premium efficiency motors for the units listed in Table 1.3 below.

Table 1.3 – Motor Replacements

Equipment ID	Location	Function	HP
CHWP-3	Chiller Room	Secondary CHW Pump	150
CHWP-4	Chiller Room	Secondary CHW Pump	150
BL-7A (SF)	Pomeroy MER-2	OR's, 1, 2, 3, 5 & 12	20
BL-9A (SF)	Pomeroy MER-2	OR's 4, 6-11, Cystology & Offices	20
BL-11 (SF)	Pomeroy MER-2	OR Hallways & Outer Offices	10
BL-12 (SF)	Pomeroy MER-2	OR Recovery Area	10

The scope of work *shall not include* the following;

- Balancing.
- Replacing bearings, belts, or sheaves if worn.

FIM#-3 Energy Management System (EMS) Installation

The scope of work shall include the following;

- Engineer, furnish and install a complete working Direct Digital Control System for the HVAC systems included in Exhibit E, "Controlled Equipment and Points List".
- The new control systems will include all required controls, sensors, relays, conduit and control wiring (except the communication link wiring between the BCUs and field panels and the BCUs and the Hospital Network).
- The new control system shall be comprised of two (2) Tracer Summit Building Control Units (BCUs), new unit controllers and sensors.
- The scope of work shall include integrating the new cooling tower controllers into the central control system.
- The scope of work shall include as-built engineered system drawings and system manuals.

- The Trane Rover Service Software Tool shall be provided along with 8 hours of related training.
- The scope of work shall include graphics for the new control points on the operator workstation.
- Following installation, a system operator training course shall be provided that will consist of 40 hours.
- The hospital will be upgraded to the latest version of Trane Tracer Summit software including any previously installed versions.
- Provide programming and/or equipment modifications to allow for the following energy savings control strategies:

Table 1.4 – EMS Control Strategies

Equipment ID	Unoccupied Setback	Economizer Control	Demand Control Vent.	Supply Air Temp. Reset	VAV Repair
Rehab Area AHU	√				
Old Dental RTU	√	√			
Catheter Lab AHU	√	√			
Lobby RTU	√	√			
Physical Med. RTU	√				
Library AHU	√				
Nursing Svc. RTU	√				
Dietary RTU	√				
1-Day Surgery AHU	√	√			
North-2 AHU	√				√
North-3 AHU	√	√			
North-4 RTU		√			
Special Care RTU		√			
Bizzozero Large RTU	√				
Bizzozero Small RTU	√				
BL-1				√	
BL-2	√			√	
BL-3				√	
BL-6	√				
BL-7A	√				
BL-9A	√				
BL-11	√			√	
BL-12	√			√	
BL-14				√	
BL-16			√		
Merriman Gym RTUs	√				
Child Care AHU-1	√				
Child Care AHU-2	√				

The scope of work *shall not include* the following;

- Control and/or monitoring of any equipment not specifically listed in Exhibit E, "Controlled Equipment and Points List".
- Labor outside of regular business hours of 7am to 3:30pm.
- Communications wiring between the BCUs and field panels, and between the BCUs and the Hospital network (To be provided by Waterbury Hospital).
- Existing valves, damper actuators and safety devices shall remain and be re-used. If an existing end device is found to be defective, SIEMENS shall inform Waterbury Hospital and replace the defective devices as an add to this contract. All pressure, flow and power inputs are considered existing and shall be re-used by the system.

FIM-4 Chiller Replacement

The scope of work shall include the following;

- Disconnect, remove, and properly dispose of (1) Centrifugal Chiller and (3) Chilled Water Pumps.
- Furnish and install (1) 1000 Ton Centrifugal Chiller and (3) Chilled Water Pumps.
- Furnish all labor, materials, and accessories required to reconnect the new chiller and pumps to the existing piping distribution system.
- Disconnect and reconnect electric power wiring to new equipment.
- Insulate new piping and accessories to match existing.
- Furnish and install (1) Automatic Transfer Switch and associated wiring modifications as shown on BVH Phase 2 drawings.
- Chiller replacement to take place in the fall when peak load drops enough to run the absorption chiller stand-alone.
- Pump replacements to take place during winter shut down.
- Furnish and install new refrigerant monitoring system.

The scope of work *shall not include* the following;

- Electrical items shown on BVH drawings related to future Cooling Tower CT-3.
- BVH contract administration fees.
- Exhaust fan and ductwork shown as Phase 2 Alternate on BVH drawings.
- Temporary cooling.

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FIM-5 Water Conservation

Plumbing Fixtures:

- Install (216) new wall mounted, wall outlet, flushometer styled 1.6 gallon per flush toilets with extended tail pieces.
- Install (65) new floor mounted, wall outlet, flushometer styled 1.6 gallon per flush toilets with extended tail pieces.
- Install (78) new ADA wall mounted, wall outlet, flushometer styled 1.6 gallon per flush toilets with extended tail pieces.
- Install (2) new ADA floor mounted, wall outlet, flushometer styled 1.6 gallon per flush toilets with extended tail pieces.
- Install (21) new 1.6 gallons per flush tank-type toilets.
- Install urinal retrofit kits for (15) urinals. SIEMENS will install flushometer retrofit kits. The retrofit kits will reduce the water usage to only one gallon per flush. These kits are manufactured specifically for urinal applications.
- Install (449) low-flow faucet aerators. These engineered aerators break the water into fine droplets and entrain air while maintaining wetting effectiveness. The new aerators will have a flow rate of 0.5 gallons per minute.
- Replace (3) existing faucets with new faucets with the ability to accept faucet restrictors.
- Install (236) low flow showerheads.
- Replace approximately (94) broken flanges with new.
- Includes Procurement of all necessary permits
- Includes removal and proper disposal of existing fixtures.

The scope of work *shall not include* the following;

- Repairing existing plumbing isolation valves.

Process Equipment:

Vacuum Water Saver Systems:

Install Vacuum Water Saver Systems for the following sterilizer units;

Table 1.5 – Sterilizer Vacuum Water Saver Systems

Sterilizer Manufacturer	Sterilizer Model	Location	Quantity
Amsco	3043	Pomeroy CSD	1
Amsco	3043	Pomeroy CSD	1

Each Vacuum Water Saver System will include the following components;

- New SIHI vacuum pump mounted beneath the sterilizer
- Controls and power wiring necessary for integration with sterilizer
- Solenoid valve, pressure regulator and backflow prevention device
- All necessary piping, valves and fittings necessary for a complete installation
- Commissioning and O&M manuals

Sterilizer Condensate Tempering Systems:

Install Condensate Tempering Systems for the following sterilizer units;

Table 1.6 – Sterilizer Condensate Tempering Systems

Sterilizer Manufacturer	Sterilizer Model	Location	Quantity
Amsco	3043	Pomeroy CSD	1
Amsco	2011	Pomeroy OR Core	1
Amsco	2011	Pomeroy OR Core	1

Each Condensate Tempering System will include the following components;

- Temperature controller set to 140 °F and mounted on wall within 5 feet of sterilizer
- Temperature sensing probe
- Solenoid valve, flow restrictor and backflow prevention device
- All necessary piping, valves and fittings necessary for a complete installation
- 120V electrical connection to wall outlet or sterilizer power
- Cut sheets and operating instructions

Kitchen Disposal/Trough Spray Control System:

- Install an inline 3 gpm adjustable flow restrictor on the city water feed to the existing nozzles that supply city water to the kitchen disposal/trough system.
- The new flow restrictor will be adjustable and will provide for adequate flow to propel waste down the trough to the basket strainer while eliminating the existing near overflow condition in the trough.
- If supplemental water flow is needed, the trough operators will continue to utilize the overhead sprays that are available.

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Cafeteria Food Tray Conveyor – Rinse Control System:

- Install a 0.5 gpm flow restrictor together with an integral adjustable timer to control the run time of the tray conveyor rinse system. The new timer will be set to operate the conveyor rinse spray for a total period of 2 hours per day.
- Scope of work includes all ancillary piping and fittings for a complete installation

Laundry Ozone System:

Install an ozone generator system for the following washer systems located in the laundry room:

Table 1.7 – Laundry Washing Machine Equipment

Manufacturer	Model	Location	Capacity (Lbs)
Braun	600 NEUT TSL.P	Laundry	600
Braun	600 NEUT TSL.P	Laundry	600
Braun	400 NEUT TSL.P	Laundry	400
Braun	N/A	Laundry	100

The scope of work will include installation of the following equipment:

- (1) CD-25G Ozone Generator / Oxygen Generator
- (1) ORP Monitor / Controller, probe and cable
- (1) #1584 Venturi Injector
- (1) ON/OFF Power Control Box
- (2) 2", (1) 1-1/2" and (1) 1" ozone solenoid valves
- (1) 2-HP Booster Pump
- (1) Degas Valve
- (1) Ozone Destruct Module
- Pressure reducing valve, pressure relief valve and (3) PVC check valves
- PVC pressure fittings and PVC pipe
- System accessory package
- Turn-key installation
- Operation and maintenance manuals
- Training of laundry personnel
- Installation of water meters on the laundry equipment to measure and verify savings

Water Cooled Air Conditioning Equipment:

Install necessary equipment/connections to eliminate the once-through cooling applications included in the table below:

Table 1.8 – Once-Through Cooling Systems

Manufacturer	Model	Building	Room	City Water Flow (GPM)	Proposed System
Mammoth	D0131H1E01	North Wing – Basement	Rm #B057 (Steve J's Office)	Est. 1.0 gpm	Install New Air-Cooled Unit
N/A	N/A	Pomeroy – Ground	Rm #0202 (Chief Sec. of Rad.)	Est. 1.0 gpm	Install New Air-Cooled Unit
N/A	N/A	Pomeroy – Ground	Rm #0201 (Assist. Dir. of Rad.)	Est. 1.0 gpm	Install New Air-Cooled Unit
York/Borg Warner	D1030-6-A	North Wing – 1st Floor	Rm #1303 (Office)	2.5	Connect to chilled & hot water loops. Includes ducting and controls to Rm #1128
York/Borg Warner	DW40-25B	Pomeroy - Ground	Rm #0231-1 (Rad. Work Rm.)	2.5	Install New Air-Cooled Unit

The scope of work will include the following:

- Provide and install new equipment as indicated in the table above
- All necessary piping, valves and fittings for a complete installation
- Insulation on all new piping
- Power and control wiring as required
- System start-up and operator training
- Asbestos removal not included

FIM-6 Plug Load Controls – Vending Machines

- Provide and install Vending Miser control systems and Snack Miser control systems as indicated in the table below:

Table 1.9 – Vending Machine Controllers

Building	# of Vending Miser Controllers for Cold Beverage Machines	# of Snack Miser Controllers for Snack Machines
Main Hospital	6	3
Merriman Hall	1	1
Children's Center	1	1
TOTALS	8	5

- Mounting of Vending/Snack Misers and motion sensors
- Install repeaters as necessary where vending machines are grouped together
- Check system performance
- Assumes access is available to all equipment

FIM-7 Steam System Improvements

As part of the detailed evaluation of the hospital, SIEMENS identified several opportunities related to the optimization of the hospital's steam delivery system. Each of these opportunities is briefly described below.

Replace Steam Traps

There is strong evidence that steam traps have failed throughout the hospital. This is primarily due to a lack of a steam trap maintenance program and the inherent failure rate of steam traps in general. SIEMENS has performed a detailed steam trap survey where all traps where physically tagged and data collected on all valves and steam using equipment throughout the Hospital. Condensate receivers with steam venting or hot return lines were identified and condensate receiver temperatures were measured. Based on some steam trap testing, on-site observations and discussions with staff we have made conservative estimates of steam trap failure.

We recommend a combination of new steam traps that are best suited for each application in the Hospital and will support the most reliable control of steam heating.

The following table identifies the quantity and type of steam traps that are included in this retrofit:

Table 1.10 – Steam Trap Replacements

Steam Trap Type	Quantity of Tubular Outlet Traps	Quantity of Float & Tubular Outlet Traps	Quantity of Bi-Metallic Traps	Totals
HP Drips	18		19	37
MP Drips	16		4	20
LP Drips	158		31	189
Unit Heaters	15	2		17
CI Rads/FT Conv	189			189
AHUs/RHs (15 psi)	8	6	2	16
AHUs/RHs	15	17		32
HEXs	10			10
DHWHs	6			6
Chiller	1			1
Equip HP	16		1	17
Equip	11	3	2	16
HUMS	16			16
TOTAL	479	28	59	566

The scope of work will include the following:

- Provide and install new steam traps as indicated in the table above
- Install Y-Strainers and blow-down valves for each new steam trap
- Cleaning of mud legs associated with this project
- Installation will occur during normal working hours
- Steam system shut downs will be provided on a timely basis
- One complete inspection and blowdown of the "in-line" steam traps strainers
- Annual stralner blow-down program to ensure optimal steam system performance

Following the installation of the new steam traps, the hospital will be provided with a detailed steam trap inventory including the following information:

- Steam trap location
- Steam system equipment application
- Steam trap information (ID#, size, model#)
- Steam pressure

Steam Distribution Insulation:

Insulation is in relatively good condition at the hospital, however, there are some locations that are missing insulation. Insulation will be installed on bare steam piping as well as custom-fit removable insulation jackets on certain steam components such as valves. This will reduce energy losses, improve system operation and reduce high temperatures within the mechanical spaces.

The scope of work includes the following:

- Furnish and install all-purpose fiberglass jacket with taped joints. Seams shall be stapled; exposed insulation shall be sealed with white mastic.
- Only valves 2 1/2" diameter and greater to have removable jackets applied. All other valves to be incorporated in pipe covering or oversized. Only valves that need to be serviced regularly will receive removable jackets.
- Unions and strainers will not be insulated
- Removable and Re-useable Valve Covers shall be fabricated on-site according to the following scope:
    - Insulation shall be 1 1/2" thick, 1200°F temperature material. Hot side shall be 1000°F cloth. Finish on outside shall be gray silicon cloth. All valve covers shall be measured and cut to fit, fabricated with pneumatic staples and secured to valve with lacing hooks and stainless steel wire.

For bare pipes, insulation thickness will be as follows:

Pipe Diameter	Insulation Thickness
2" and less	1"
3" – 6"	1 1/2"
8" and greater	2"

The following table identifies the steam distribution components that were identified during the detailed study that have missing or ineffective insulation. These components will be insulated as part of this project.

Table 1.11 – Steam System Insulation Quantities

Nominal Pipe Size (Inches)	Total Pipe Length (ft)	Number of Valves and Fittings
1	0	7
1 ¼	10	9
1 ½	45	3
2	60	3
2 ½	75	0
3	25	2
4	0	3
5	0	0
6	45	2
TOTALS	*260*	*29*

Repair Steam & Condensate Leaks

- A total of seven (7) low pressure leaks and three (3) high pressure leaks were identified during the detailed survey. Leaking was observed including: high pressure steam flanges, packing leaks in high and medium pressure valves, holes in return lines, receiver pumps leaking, receiver tanks leaking through their fittings, etc. These leaks will be repaired as part of this project.

- It was also discovered that three (3) condensate return pumps have failed resulting in hot condensate leaking to the floor or drain. These pumps will be either repaired or replaced as part of this project.

Install Radiator Control Valves

The existing radiators and fin tube convectors have various types of control valves – manual, pneumatic and thermostatic. Most of the control valves are manual valves, which are typically left on all the time as occupants do not understand or know how to adjust them. We have found that a percentage of the valves with pneumatic controls are not operating properly due to failed valves, or problems with the compressed air system resulting in failed open valves. Many of the rooms and buildings in the hospital are overheating because they lack control. As a result, there are several areas that are grossly overheated with measured temperatures as high as 83 °F. As a result, patients and staff use windows to control heat resulting in wasted energy. In some cases air conditioners are being used to control the heat in winter. Installation of a reliable thermostatic radiator valve will improve the control of the heating system and reduce the need to open windows to control temperature in the buildings.

The scope of work will include the following:

- Install (179) new thermostatic radiator control valves on applicable radiation units
- The new valves shall have cartridge type packing and unions instead of the "throwaway" type.
- The new valves shall be serviceable in-line, when the steam or hot water is present
- The new valves will come with a minimum 5-year warranty.

FIM-8 Building Envelope Improvements

The air leakage points identified below will be mitigated by sealing gaps, cracks and holes, using appropriate materials and systems. A total of 15.5 square feet of crack area will be sealed as part of this measure, as described below.

Pomeroy Pavilion:

- Basement:
  - weather-strip 3 exterior doors
  - weather-strip 2 stairwell doors
  - weather-strip 1 set of double doors
  - weather-strip 1 (8'x8') overhead door
- Ground Floor:
  - weather-strip 2 exterior doors
  - weather-strip 2 stairwell doors
- 1st Floor:
  - weather-strip 3 stairwell doors

- 2nd Floor – 9th Floor (Typical)
  - weather-strip 2 stairwell doors per floor

Main Building

- Basement
  - weather-strip 8 doors including stairwells
- Ground Floor:
  - weather-strip 20 doors including stairwells
- Main Floor:
  - weather-strip 10 doors including stairwells
  - weather-strip 1 set of double doors
- 2nd Floor:
  - weather-strip 8 doors including stairwells
- 3rd Floor:
  - weather-strip 6 doors including stairwells
- 4th Floor:
  - weather-strip 9 doors including stairwells and parking lot link

Merriman Hall:

- Basement:
  - weather-strip 1 door
- Ground Floor:
  - weather-strip 2 doors
- 1st Floor:
  - weather-strip 1 door

Reed Surgery Center

- weather-strip 1 set of double doors

FIM-9 Power Factor Correction

Install a turnkey, facility-wide power factor correction system with harmonic filters. The new system will have a total system kVAr of 1175 at 480 volts with harmonic filtering utilizing both

fixed and automatic switching equipment. The project will include the equipment listed in the table below:

Table 1.12 – Power Factor Correction Equipment

Quantity	Model Number	Description
2	IDLP3300FA05W	Automatic 480 Volt, 300 kVAr w/ Reactors, Breaker & BFI
1	HSICS2200F333F	480 Volt, 200 kVAr Fixed Capacitor w/ 3 Fuses & No Lights
1	HSICS1100F333F	480 Volt, 100 kVAr Fixed Capacitor w/ 3 Fuses & No Lights
1	HSICS2175F333F	480 Volt, 175 kVAr Fixed Capacitor w/ 3 Fuses & No Lights
2	HSICS1050H333F	600 Volt, 50 kVAr Fixed Capacitor w/ 3 Fuses & No Lights
1	MHL36300 Square D	High Interrupt 300 Amp. – 600 Volt 3 Pole
1	8MA1000S	Square D Enclosure for 1000 Ampere Breaker NEMA 1

The total cost assumes the use of an existing 800 Ampere breaker in Side A of the main double ended switch gear. This system is designed to operate in either an open or closed tiebreaker position. This system is designed with harmonic filtering to allow its operation with the existing Simplex time clock system. Total cost assumes adequate space shall be allowed in the electrical rooms for the equipment listed in the table above.

Scope of work to include the following:

- Harmonic monitoring controller with alarm and corrective action programming
- 5-Year manufacturers warranty on high quality liquid filled capacitors
- Capacitor rated contractors
- Shipping to your dock
- Commissioning as needed by factory authorized representative
- Breaker equipment as listed
- Complete installation of the above which includes all materials, non-union labor rates, and insurance to form a complete, operable electrical installation in accordance with the National Electric Code and local authorities.

FIM-10 Install Off-Peak Boiler

This project has been removed from the scope of work.

FIM-11 Install Boiler Stack Economizer

Provide and install one (1) new boiler exhaust economizer and components to recover exhaust waste heat from the existing Cleaver Brooks #2 steam boiler (Serial # W-3507).

The scope of work is to include the following:

- Purchase and install new economizer.
- Remove existing economizer and related breeching, adapters, hangers and pipe.
- Disconnect and reconnect existing steam lines and gas vents as required for the installation.
- Dispose economizer off site.
- Connect new economizer with new breeching and transitions as needed.
- Connect new boiler feed pipe and isolation valves as needed.

The scope of work *shall not include* the following;

- Additional Overtime
- Standby boiler

FIM-12 Electric Meter Consolidation (Merriman Hall)

This project will eliminate the existing independent electric utility service at Merriman Hall (Rate 35) and add this load to the main hospital service (Rate 58).

The scope of work will include the following:

- Install new 225 amp 65k AIC 480 volt circuit breaker in main 480 volt switchboard
- Run approximately 185 feet of 2.5 inch EMT conduit with corresponding wiring
- Install appropriate sized junction box on the exterior of the building.
- Run approximately 185 feet of 2.5 inch PVC Schedule 80 conduit with corresponding wiring from the exterior junction box to the new transformer. Core-bore holes and fire-stop as needed.
- Dig hole into the side of the existing transformer pad to allow conduits to be installed
- Purchase and install 1-new 225KVA Nema 3R 480 volt primary/208 volt secondary transformer in the place of the existing CL&P transformer. Rig in the new transformer and remove the existing transformer.
- Make all terminations in the transformer for both the primary and secondary feeders
- Electrical Permit Fees

The scope of work *shall not include* the following;

- Standby generator

FIM-13 HVAC Recommissioning (BL-3)

Blower unit BL-3 is located in MER-1 and serves the Radiology Department on the ground floor of the Pomeroy Building. This unit was thoroughly inspected by SIEMENS technicians to identify any deficiencies that would result in inefficient or improper operation. As a result, the following deficiencies were identified and will be corrected as described below:

- The 1/2" one third steam valve was found to be leaking control air through the actuator diaphragm. As a result, the valve was unable to close even under full pneumatic pressure, therefore allowing steam to enter the steam coil on a continuous basis. This will result in unnecessary steam consumption during the non-heating season and will require additional chilled water consumption to overcome the additional heat load that is added to the unit. SIEMENS will provide materials and labor to install a new actuator and ensure proper valve operation.

- Air was found to be leaking around one of the access doors on the outlet (positive) side of the supply fan. This access door is located on the far side of the unit by wall. The gasketing around the door was found to be missing and/or ineffective, resulting in conditioned air being released to the mechanical space. SIEMENS will provide materials and labor to replace the door gasketing and ensure a tight seal.

- The unit was not equipped with a freeze protection system and the outdoor air dampers did not close completely when the unit was shut down. This could lead to freezing coil issues during the winter, especially during a planned or unplanned shutdown if the outdoor air dampers do not close properly. The risk of a freezing coil will also be increased following the repair of the leaking steam valve. SIEMENS will provide all labor and materials to install a freeze protection system for the unit and repair the outdoor air dampers so they close completely when commanded to do so.

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Article 2: FIM Work Implementation Period

2.1 Commencement of Work:
2.1.1 SIEMENS shall commence the Work within 30 days of the Effective Contract Date. SIEMENS shall perform the Work diligently and shall complete the Work no later than 14 months from the Effective Contract Date.
2.2 *Milestones*: Within 30 days of the Effective Contract Date, SIEMENS will provide an implementation schedule showing ECM milestones.

Article 3: Scope of Performance Assurance Technical Support Program

SIEMENS will provide a Performance Assurance Report annually per the guidelines of Exhibit C, within ninety (90) days of the end of each Guarantee Year. The report will include a comparison of the Realized Annual Savings and the Guaranteed Savings.

Please reference Exhibit C for more detailed information on the Measurement and Verification procedures that will be performed under this Agreement.

Article 4: Scope of Maintenance Services Technical Support Program

The Maintenance Services Technical Support Program will include the following:

Energy Management System (EMS) Installation

Automation controls can drift out of calibration with changes in mechanical component performance characteristics, building use, and climatic conditions. We will provide technical expertise with respect to preventive maintenance in accordance with a program of standard maintenance routines as determined by our experience, equipment application and location. Through this service we'll extend equipment life, reduce energy waste, and reduce the risk of costly and disruptive breakdowns.

Specifically, we will provide the following related to preventive maintenance of the Trane Tracer Summit Energy Management System:

- On an annual basis, SIEMENS shall provide the services of a qualified controls technician to work with hospital facility personnel to provide preventive maintenance for the Energy Management System and related components
- This service shall be limited annually to 40 hours of on-site support during normal business hours (Monday through Friday, 8am – 5pm), and 20 hours of on-site support during premium hours.

Hospital Responsibilities:

The Hospital will be responsible for the day to day operation and full maintenance of the existing and new EMS systems (including Trane, Andover and Delta). This will include any preventive

maintenance (with support from SIEMENS as described above), and any repairs, software upgrades, etc. associated with the EMS.

Chiller Replacement

SIEMENS shall provide preventive maintenance services on the new 1000 ton centrifugal chiller described in Article 1 of this Exhibit. The services shall include the following annually:

- Seasonal start-up
- Six (6) total operating inspections (including start-up and shut-down)
- Annual condenser tube cleaning
- Filter changes
- Winter shut-down of chiller
- Emergency service response
    - Technicians shall respond around-the-clock to ensure proper and reliable operation of the chiller (24 Hours/Day – 7 Days/Week, including holidays)
    - The hospital will be separately invoiced for all labor and materials required for emergency services
- 1st through 5th year full unit parts and labor warranty (including refrigerant) is included in the base bid

Hospital Responsibilities:

The Hospital will be responsible for the day to day operations of the new chiller. Following the expiration of the 5-year warranty, the Hospital will also be responsible for any necessary repair work to the new chiller. The Hospital will continue to have full responsibility for the maintenance of the existing Trane absorber which will remain, as well as all the pumps and ancillary equipment associated with the chiller plant.

Laundry Ozone System

The preventive maintenance of your laundry ozone system is our utmost concern to ensure the Hospital is receiving the full benefits of the ozone system.

Maintenance: A minimum of three (3) annual site visits by qualified personnel will be provided to ensure all maintenance requirements from the ozone laundry system manufacturer are performed.

Maintenance Parts: Annual installation of the below maintenance parts are included in this agreement to handle the preventative maintenance of your ozone laundry system.

- Generator filter
- Ozone tubing Check valve
- Tubing from Generator to Injector

Hospital Responsibilities:

The Hospital will be responsible for daily monitoring of the ozone system for any alarm conditions, checking pressure levels for the venturi nozzle, and for powering the system on and off. Hospital personnel will be thoroughly trained to perform these tasks. The Hospital shall notify SIEMENS if any alarm conditions shall exist.

Steam Trap Replacement

Any steam system, whether a mechanical steam trap or the proposed SteamLoc® system, should have a program to "blow-down" strainers to remove dirt and scale from the steam distribution system. Dirt and Scale are one of the reasons the moving parts in mechanical steam traps fail. Also, the strainers may plug up causing system failure. We recommend an annual "blow-down" of the strainers to ensure optimal performance of the steam system. This is in addition to the cleaning of mud legs which will be performed during the initial installation.

The following tasks will be performed annually with respect to the new steam traps that will be installed as described in Article 1 of this Exhibit:

- In an effort to facilitate team coordination and maintain optimal system performance, SIEMENS will work with hospital personnel to perform an annual blow-down of all the new steam traps installed under this agreement. Blow-down includes briefly turning on the blow-down valve on each SteamLoc® strainer, under steam pressure, to remove material collected in the strainer. The Hospital will be responsible for an additional 6-month blow-down of the new traps to ensure optimal system performance throughout the year (Please reference *Hospital Responsibilities* section below).
- Screens in Thermostatic traps will be spot-checked.
- A written report of steam system issues will be provided.
- In addition, SIEMENS will work with Hospital staff including training of new personnel on trap operation and repair, blow-down procedure and steam "system" performance.

SteamLoc® Warranty:

SIEMENS has proposed the SteamLoc® Tubular Outlet Steam Traps for the Hospital along with other steam traps including Velan Bi-Metallic Steam Traps. SIEMENS will determine the best steam trap for each application. SIEMENS will take responsibility for applications where a SteamLoc® Tubular Outlet steam trap is sized incorrectly, if a SteamLoc® Tubular Outlet steam trap is misapplied on an application where it will not work as designed or if a steam trap becomes a consistent problem.

The determination of trap performance will be based on temperature readings before and after the steam trap. A steam trap is deemed to be working properly if the upstream temperature is close to the saturation temperature and the downstream temperature is less than 212 °F. This

indicates condensate has not backed up before the steam trap (a trap has failed closed) and steam is not passing into the condensate line (a trap has failed open).

If a steam trap installed under this Agreement fails closed on more than one occasion, the Hospital shall notify SIEMENS within 10 days of such occurrence. Following notification, SIEMENS will inspect the steam trap in question to determine the application is suitable and to confirm proper sizing for the application. SIEMENS will cover the cost of labor and materials to replace the steam trap if it is not sized correctly, is the wrong application or is a consistent problem. SIEMENS will install a new steam trap that is the best trap for the application.

It is understood that a steam system has many component parts that interact and can cause problems with the steam system including the steam traps. SIEMENS makes this offer in the spirit of cooperation to ensure the steam trap project is a success for both the Hospital and SIEMENS.

If the Hospital requires SIEMENS to make a site visit to replace a SteamLoc® trap that has "failed" and it is determined that it is functioning properly; or the Hospital requires SIEMENS to solve a problem, the cause of which is blamed on a SteamLoc® trap, but in fact is not caused by the SteamLoc® trap, then SIEMENS will be paid for the service work performed and travel time.

On the initial installation, SIEMENS is only responsible for faulty piping which is the least distance from the SteamLoc® trap of either three feet or to the first joint. After the initial installation, all piping is the responsibility of the Hospital.

Hospital Responsibilities:

The Hospital will be responsible for maintaining records of steam trap repair requirements, by tag number. As described above, if a steam trap installed under this Agreement fails closed on more than one occasion, the Hospital shall notify SIEMENS within 10 days of such occurrence.

The Hospital will also be responsible for an additional 6-month blow-down of all the new steam traps installed under this agreement. This blow-down will be in addition to the annual blow-down performed as part of the annual inspection.

The Hospital will also be responsible for replacing any mechanical non- SteamLoc® (non-tubular outlet) traps that may fail following the installation. SIEMENS will only be responsible for the failure of SteamLoc® traps as described in the *SteamLoc® Warranty* section above.

Power Factor Correction System

An annual preventive maintenance program will be provided for the new power factor correction equipment described in Article 1 of this Exhibit. The following tasks will be performed on an annual basis:

Shut-down and cleaning:
An initial recording of the vital information including Catalog # and serial number of the system will be documented on a field report form. The systems will be stepped down and the power

shut off. A thorough vacuuming and cleaning inside and outside the enclosures of the system will be provided. During the cleaning process components will be visually inspected for any problems.

Torque adjustment of connections:
The tightness of Electrical power connections will be verified, beginning with the Main Breaker or Main Lug connections where the power source enters the power factor correction system. The tightening will be accomplished using torque wrenches and the appropriate socket heads to adjust all connections to precise torque settings recommended by the manufacturer.

Contactor and capacitor inspection:
After tightening all connections, the contactors will be disassembled and the load contacts inspected for arcing, alignment and wear. The mechanical integrity of the air coil inductors and their retention frames will be checked. Fuses will be checked for continuity, and each capacitor cell will be checked with a Fluke Digital Capacitance Meter to determine if any cells need replacement. The mechanical retention hardware will also be tightened and checked for integrity. Individual cells will be inspected for leaking and case swelling.

Inspection of control circuit components:
After all power components are checked, the control circuit fuses and connections to the controller will be checked for proper connection, torque, size, and integrity. In addition, ground circuit integrity and enclosure mechanical-electrical interlocking will be verified. Component identification will be checked with manufacturer's original drawings and marked accordingly.

Load and harmonics test:
Once the Cleaning, Inspecting, necessary repairs and tightening of all components has been completed, a three phase harmonics analyzer will be connected to the main power feed of the power factor correction system. Lock out/Tag out devices are removed, and power is restored to the system. Upon power up, the VAR Controller will be placed in program mode, and the nine adjustable control parameters will be checked, recorded and adjusted if necessary. The controller will then be placed in Manual mode and each capacitor step will be turned on individually. The current, voltage and Harmonic distortion for each phase will be recorded into a memory pack. Following the manual test, the controller will be placed in automatic mode, and the automatic operation will be observed and recorded. Once the system has stepped up to the Set point on the controller, the Harmonics analyzer will be set to record the Voltage Current and distortion for all three phases.

Comprehensive report and service card:
A comprehensive report will be compiled based on the field report and the tests recorded by the Harmonics analyzer. The report will consist of an Executive summary, System checklist, Load Test results, Harmonics Spectrum and Waveform graphs. A Preventive Maintenance Service Schedule Card will be placed on the door of the power factor correction system. This will record when the system was installed, and when it has been serviced.

Hospital Responsibilities:

The Hospital will be responsible for monitoring the new power factor correction systems for any alarm conditions. The alarm points can be monitored through the EMS since they will be picked up by the new controls. The Hospital shall notify SIEMENS if any alarm conditions shall exist.

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SIEMENS

Exhibit B-List of SBT Provided Equipment

Siemens Building Technologies, Inc.
Technical Support Program

List of SBTI Provided Equipment

Qty	Equipment	Manufacturer	Model No.	Size	R&R Coverage See Code Key
1	VFD for Boiler Feed Water Pump #1	TBD	TBD	30 HP	
1	VFD for Boiler Feed Water Pump #2	TBD	TBD	30 HP	
1	VFD for Boiler Feed Water Pump #3	TBD	TBD	30 HP	
1	VFD for Secondary Chilled Water Pump CHWP-3	TBD	TBD	150 HP	
1	VFD for Secondary Chilled Water Pump CHWP-4	TBD	TBD	150 HP	
1	VFD for Hot Water Reheat Pump RHP-7	TBD	TBD	5 HP	
1	VFD for Hot Water Reheat Pump RHP-8	TBD	TBD	5 HP	
1	VFD for BL-7A	TBD	TBD	20 Hp	
1	VFD for BL-9A	TBD	TBD	20 HP	
1	VFD for BL-11	TBD	TBD	10 HP	
1	VFD for BL-12	TBD	TBD	10 HP	
1	Premium Efficiency Motor for Secondary Chilled Water Pump CHWP-3	TBD	TBD	150 HP	
1	Premium Efficiency Motor for Secondary Chilled Water Pump CHWP-4	TBD	TBD	150 HP	
1	Premium Efficiency Motor for BL-7A	TBD	TBD	20 HP	
1	Premium Efficiency Motor for BL-9A	TBD	TBD	20 HP	
1	Premium Efficiency Motor for BL-11	TBD	TBD	10 HP	
1	Premium Efficiency Motor for BL-12	TBD	TBD	10 HP	
1	Centrifugal Chiller	TBD	TBD	1000 Nominal Tons	
1	Secondary Chilled Water Pump CHWP-2	TBD	TBD	2000 GPM	
1	Secondary Chilled Water Pump CHWP-3	TBD	TBD	3780 GPM	
1	Secondary Chilled Water Pump CHWP-4	TBD	TBD	3780 GPM	
1	Sterilizer Vacuum Pump	SIHI	N/A	1.5 HP	
1	Ozone Generator System	Ozone Solutions	RC25-4	2 HP	
566	Steam Traps	Steamlock, Velan	Various	Various	
179	Thermostatic Radiator Control Valves	Istec	Various	Various	
1	Power Factor Correction System	GE	N/A	1175 kVAr	
1	Dual Fuel Steam Boiler	Cleaver Brooks	TBD	300 BHP	
1	Boiler Stack Economizer	TBD	TBD	TBD	
1	Power Transformer	TBD	TBD	225 KVA	

SIEMENS

Exhibit B-List of SBT Provided Equipment

2	Above Ground Storage Tank	TBD	TBD	30,000 Nominal Gallons	
1	Above Ground Storage Tank	TBD	TBD	10,000 Nominal Gallons	
1	Electronic Tank Gauge System	Veederoot	TLS3000-1	N/A	
260	Linear Feet of Pipe Insulation	TBD	TBD	Varies	
29	Insulation Jackets for Valves & Fittings	TBD	TBD	Varies	
1351	Lighting Fixtures / Lamps / Ballasts	Sylvania	TBD	N/A	
2727	Fixtures Controlled By Occupancy Sensors	Sensor Switch	TBD	N/A	
382	Plumbing Fixtures	TBD	TBD	N/A	
15	Flushometers	TBD	TBD	N/A	
688	Plumbing Accessories	TBD	TBD	N/A	
2	Building Control Units	Trane	N/A	N/A	
500	Sensors & Wiring	Trane	N/A	N/A	
13	Vending Machine Controls	Bayview Tech	TBD	N/A	

FILING #0002419467 PG 26 OF 26 VOL U-00345
FILED 10/11/2006 11:00 AM PAGE 01563
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

EXHIBIT B

Contract Agreement between Siemens Financial Services and Waterbury Hospital, The. Contract # 319-0050975-002, Equipment location: 64 Robbins Street, Waterbury, CT 06721

FILING OFFICER STATEMENT

INTERNAL USE ONLY

FILING #0002419587 PG 01 OF 01 VOL U-00345
FILED 10/16/2006 09:46 AM PAGE 01645
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. Identification of the Record to which this FILING OFFICER STATEMENT re

1a. INITIAL FINANCING STATEMENT FILE # 2419462

1b. RECORD # TO WHICH THIS STATEMENT RELATES 2419507

2. Describe the inaccuracy of the filing office index.

Correct File Time S/B 1:45 PM not 8:30AM

3. Describe filing office action taken to correct index.

Valerie Perez
SUPERVISOR

Rev. 10/01/2001

FILING OFFICER STATEMENT

INTERNAL USE ONLY

FILING #0002419604 PG 01 OF 01 VOL U-00345
FILED 10/16/2006 10:31 AM PAGE 01668
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. Identification of the Record to which this FILING OFFICER STATEMENT rel

1a. INITIAL FINANCING STATEMENT FILE # 2419467

1b. RECORD # TO WHICH THIS STATEMENT RELATES 2419604

2. Describe the inaccuracy of the filing office index.

Correct File Time s/p 11:00 AM Not 1:45 PM

incorrect information given on 1st Correction

3. Describe filing office action taken to correct index.

Valerie Bares

SUPERVISOR

Rev. 10/01/2001

[redacted]

FILING #0002828623 PG 01 OF 01 VOL U-00444
FILED 07/29/2011 08:30 AM PAGE 00780
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]
Corporation Service Company 1-800-858-5294

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

59931696 - 356750 - 7/27/2011
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecticut (S.O.S.)

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE #
0002419467 10/11/2006

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS.

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to security interest(s) of the Secured Party authorizing this Termination Statement.

3. ☒ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to security interest(s) of the Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law.

4. ☐ ASSIGNMENT (full or partial): Give name of assignee in item 7a or 7b and address of assignee in item 7c; and also give name of assignor in item 9.

5. AMENDMENT (PARTY INFORMATION): This Amendment affects ☐ Debtor or ☐ Secured Party of record. Check only one of these two boxes.

Also check one of the following three boxes and provide appropriate information in items 6 and/or 7.

☐ CHANGE name and/or address: Please refer to the detailed instructions in regards to changing the name/address of a party. ☐ DELETE name: Give record name to be deleted in item 6a or 6b. ☐ ADD name: Complete item 7a or 7b, and also item 7c; also complete items 7e-7g (if applicable).

6. CURRENT RECORD INFORMATION:

6a. ORGANIZATION'S NAME The Waterbury Hospital

OR

6b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7. CHANGED (NEW) OR ADDED INFORMATION:

7a. ORGANIZATION'S NAME

OR

7b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

7d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	7e. TYPE OF ORGANIZATION	7f. JURISDICTION OF ORGANIZATION	7g. ORGANIZATIONAL ID #, if any
				☒ NONE

8. AMENDMENT (COLLATERAL CHANGE): check only one box.

Describe collateral ☐ deleted or ☐ added, or give entire ☐ restated collateral description, or describe collateral ☐ assigned.

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT (name of assignor, if this is an Assignment). If this is an Amendment authorized by a Debtor which adds collateral or adds the authorizing Debtor, or if this is a Termination authorized by a Debtor, check here ☐ and enter name of DEBTOR authorizing this Amendment.

9a. ORGANIZATION'S NAME Siemens Financial Services, Inc.

OR

9b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

10. OPTIONAL FILER REFERENCE DATA 319-0050975-002 GdJ 07/25/11

59931696

FILING OFFICE COPY — UCC FINANCING STATEMENT AMENDMENT (FORM UCC3) (REV. 05/22/02)

10-300607

[redacted]

UCC FINANCING STATEMENT
FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michael P. Botelho, Esq.
Updike, Kelly & Spellacy, P.C.
One State Street
Hartford, CT 06103

FILING #0002791044 PG 01 OF 05 VOL U-00430
FILED 12/22/2010 12:00 PM PAGE 02174
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S EXACT FULL LEGAL NAME – insert only one debtor name (1a or 1b) – do not abbreviate or combine names

1a. ORGANIZATION'S NAME: The Waterbury Hospital

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 Robbins Street	Waterbury	CT	06708	USA

1d. See Instructions	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		corporation	Connecticut	☒ None

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME – insert only one debtor name (2a or 2b) – do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. See Instructions	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ None

3. SECURED PARTY'S NAME (or NAME of TOTAL ASSIGNEE of ASSIGNOR S/P) – insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: RBS Citizens, National Association

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
63 Eugene O'Neill Drive	New London	CT	06320	USA

4. This FINANCING STATEMENT covers the following collateral:

The Debtor hereby grants to the Secured Party a security interest in the collateral described in Schedule A, attached hereto and made a part hereof.

5. ALTERNATIVE DESIGNATION [if applicable]: ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA
582523 CT SOS (Bond Loan)

FILING OFFICE COPY – NATIONAL UCC FINANCING STATEMENT (FORM UCC1) (REV. 05/22/02)

582523

FILING #0002791044 PG 02 OF 05 VOL U-00430
FILED 12/22/2010 12:00 PM PAGE 02175
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

SCHEDULE A TO

UCC FINANCING STATEMENT

(Secretary of the State)

Debtor: The Waterbury Hospital
64 Robbins Street
Waterbury, CT 06708

Secured Party: RBS Citizens, National Association
63 Eugene O'Neill Drive
New London, CT 06320

Collateral:

(a) All that certain tract or parcel of land more particularly described and set forth in Schedule 1 attached hereto to this Schedule A and made a part hereof;

(b) All tenements, hereditaments, easements, appurtenances, passages (and all waters, water courses and riparian rights, if any), pipes, conduits, electrical and other utility lines, other rights, liberties and privileges thereof or in any way now or hereafter appertaining to the Mortgaged Property, including any other claim at law or in equity as well as any after acquired title, franchise or license and the reversion and reversions and remainder and remainders thereof, and all of the estate, right, title, claim or demand whatsoever of the Debtor therein and in the streets, ways and areas adjacent thereto;

(c) All buildings and other improvements of every kind and description now or hereafter erected or placed on the Mortgaged Property or any part thereof owned by the Debtor, and all of the right, title and interest of the Debtor in and to all materials intended for construction, reconstruction, alteration and repairs of such improvements now or hereafter erected thereon, all of which materials shall be deemed to be included within the Mortgaged Property immediately upon the delivery thereof to the Mortgaged Property, and all fixtures, Building Service Equipment, and all renewals or replacements thereof or articles in substitution therefor; it being mutually agreed that all the aforesaid property owned or to be owned by the Debtor and placed by it on the Mortgaged Property and such buildings and improvements shall, so far as permitted by law, be deemed to be affixed thereto and covered by the Mortgage;

(d) All of the estate, right, title and interest now owned or hereafter acquired by the Debtor in and to any and all sidewalks and alleys, and all strips and gores of land, adjacent to or in connection with the Mortgaged Property;

(e) All present and future leases and licenses of space in the buildings and improvements now or hereafter erected on the Mortgaged Property (collectively "leases", and individually "lease") and the rents, revenues, income, issues and profits thereunder subject, however, to the right of the Debtor to receive and use the same and to exercise all rights and privileges as landlord under all of the leases until an Event of Default shall have occurred and be continuing under the Mortgage, together with all the rights and privileges of the Debtor as landlord thereunder;

(f) All unearned premiums accrued, accruing or to accrue under any and all insurance policies now or hereafter obtained by the Debtor pursuant to the provisions of the Mortgage;

(g) All proceeds of the conversion, voluntary or involuntary, of any of the foregoing into cash or liquidated claims, including, but without limitation, proceeds of insurance provided for in the Mortgage and proceeds of condemnation awards and awards for restriction of access to, or change of grade of, streets;

(h) All transferable building service, building maintenance, construction, management and other similar agreements and contracts, written or oral, express or implied, now or hereafter entered into arising or in any manner related to the construction, design, improvement, use, operation, occupation, enjoyment, sale, conversion or other disposition (voluntary or involuntary) of the Mortgaged Property, or the buildings and improvements now or hereafter located thereon, or any other interest in the Mortgaged Property, or any combination thereof, including all property management agreements, sales contracts, contract deposits, earnest money deposits, prepaid items and payments due and to become due thereunder, and further including all payment and performance bonds, construction guaranties, warranties, construction contracts, architects' agreements, general contract agreements, design agreements, engineering agreements, technical service agreements, architectural plans and specifications, sewer and water and other utility agreements, permits, approvals, licenses, building permits, service contracts, advertising contracts, purchase orders and equipment leases; and

(i) All proceeds and products of the foregoing of every type.

All of the foregoing described property, rights, privileges, interests and franchises more particularly described in paragraphs (a) through (i) above herein granted are intended to be, and are collectively referred to herein as, the "Mortgaged Property."

All terms not otherwise defined herein shall have the meaning set forth in that certain Open-End Mortgage Deed, Security Agreement and Financing Statement dated as of December 22, 2010 by Debtor in favor of Secured Party.

FILING #0002791044 PG 04 OF 05 VOL U-00430
FILED 12/22/2010 12:00 PM PAGE 02177
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

SCHEDULE 1 TO

UCC FINANCING STATEMENT

Debtor: The Waterbury Hospital
64 Robbins Street
Waterbury, CT 06708

Secured Party: RBS Citizens, National Association
63 Eugene O'Neill Drive
New London, CT 06320

FIRST PARCEL: A certain tract of land with the Hospital and other buildings and improvements thereon standing, bounded:

NORTHERLY	by land of The Waterbury Hospital, formerly of Loren Carter, being the land hereafter described;
EASTERLY	by Watertown Avenue;
SOUTHERLY	by Robbins Street; and
WESTERLY	by Grandview Avenue.

Containing twenty-four (24) acres, more or less.

Being the same premises conveyed to The Waterbury Hospital by Charles L. and Walter W. Holmes by deed dated February 18, 1907, recorded February 25, 1907, in Vol. 202, Page 553 of the Waterbury Land Records, excepting a portion conveyed by The Waterbury Hospital to the City of Waterbury for highway purposes by deed dated June 20, 1940, and recorded August 21, 1940, in Vol. 506, Page 191 of said land records.

SECOND PARCEL: Consisting of Five Pieces, being shown on a Map entitled "Map of Woodside, Waterbury, Conn. A.J. Patton, Surveyor", on file in the Waterbury Town Clerk's Office in Map Book 1, Page 25, and containing eighteen (18) acres, more or less, to wit:

First Piece: Lots Nos. 38, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61,the southerly 40' of Lot 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89 and 90, as shown on said Map.

Second Piece: The southerly 145 feet of Lots Nos. 39 and 40, as shown on said Map.

Third Piece: Being the Homestead as shown on said Map, bounded

NORTHERLY	135 feet on Hale Street, so-called;
EASTERLY	425.74 feet in curved line on Winthrop Terrace, so-called;
SOUTHERLY	143.46 feet on Carter Avenue, so-called; and
WESTERLY	341.76 feet on Lots Nos. 61 and 53, as shown on said Map.

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FILED 12/22/2010 12:00 PM PAGE 02178
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Fourth Piece: Bounded:

NORTHERLY	running to a point at the junction of Carter Avenue, so-called, and Watertown Avenue;
EASTERLY	on Watertown Avenue;
SOUTHERLY	on land of The Waterbury Hospital;
WESTERLY	on Lot No. 90 as shown on said Map; and
NORTHWESTERLY	and again WESTERLY on Carter Avenue, so-called.

Being the same land conveyed to The Waterbury Hospital by L. Russell Carter, Executor under the Will of Loren R. Carter by deed dated and recorded November 13, 1952, in Vol. 667, Page 49 of the Waterbury Land Records.

Together with any and all rights under easement from John W. Potter to Loren R. Carter dated May 14, 1917 recorded in Vol. 282, Page 177 of the Waterbury Land Records.

Excluding from said Parcels the properties described in a Certificate of Taking by the State of Connecticut, dated March 21, 1963 and recorded in Volume 842, Page 30 and in a Quit Claim Deed from Waterbury Hospital to the State of Connecticut dated June 7, 1963 recorded in Volume 847, Page 397, each of the Waterbury Land Records.

Together with the benefits of a certain Agreement by the City of Waterbury with Loren R. Carter dated December 10, 1907, recorded November 4, 1931 in Volume 450, Page 625 of the Waterbury Land Records. While this is appurtenant, if still valid, the location of the steps and wall is on property of The Waterbury Hospital.

[redacted]

FILING #0003067900 PG 01 OF 01 VOL U-00559
FILED 07/22/2015 08:30 AM PAGE 02445
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT AMENDMI

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Corporation Service Company 1-800-858-5294

B. E-MAIL CONTACT AT FILER (optional)
SPRFiling@cscinfo.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

102414968 - 372200
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecticut
(S.O.S.)

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE NUMBER
0002791044 12/22/2010

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS
Filer: attach Amendment Addendum (Form UCC3Ad) and provide Debtor's name in item 13

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to the security interest(s) of Secured Party authorizing this Termination Statement

3. ☐ ASSIGNMENT (full or partial): Provide name of Assignee in item 7a or 7b, and address of Assignee in item 7c and name of Assignor in item 9
For partial assignment, complete items 7 and 9 and also indicate affected collateral in item 8

4. ☑ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to the security interest(s) of Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law

5. ☐ PARTY INFORMATION CHANGE:

Check one of these two boxes: AND Check one of these three boxes to:

This Change affects ☐ Debtor or ☐ Secured Party of record

☐ CHANGE name and/or address: Complete item 6a or 6b; and item 7a or 7b and item 7c
☐ ADD name: Complete item 7a or 7b, and item 7c
☐ DELETE name: Give record name to be deleted in item 6a or 6b

6. CURRENT RECORD INFORMATION: Complete for Party Information Change - provide only one name (6a or 6b)

6a. ORGANIZATION'S NAME THE WATERBURY HOSPITAL

OR

6b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

7. CHANGED OR ADDED INFORMATION: Complete for Assignment or Party Information Change - provide only one name (7a or 7b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name)

7a. ORGANIZATION'S NAME

OR

7b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

8. ☐ COLLATERAL CHANGE: Also check one of these four boxes: ☐ ADD collateral ☐ DELETE collateral ☐ RESTATE covered collateral ☐ ASSIGN collateral

Indicate collateral:

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT: Provide only one name (9a or 9b) (name of Assignor, if this is an Assignment)
If this is an Amendment authorized by a DEBTOR, check here ☐ and provide name of authorizing Debtor

9a. ORGANIZATION'S NAME Citizens Bank, N.A. Formally Known As RBS Citizens, N.A.

OR

9b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

10. OPTIONAL FILER REFERENCE DATA: Debtor: THE WATERBURY HOSPITAL 102414968

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michael P. Botelho, Esq.
Updike, Kelly & Spellacy, P.C.
One State Street
Hartford, CT 06103

FILING #0002791045 PG 01 OF 02 VOL U-00430
FILED 12/22/2010 12:00 PM PAGE 02179
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S EXACT FULL LEGAL NAME – insert only one debtor name (1a or 1b) – do not abbreviate or combine names

1a. ORGANIZATION'S NAME: The Waterbury Hospital

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 Robbins Street	Waterbury	CT	06708	USA

1d. TAX ID #: SSN OR EIN	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		Corporation	Connecticut	☒ None

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME – insert only one debtor name (2a or 2b) – do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. TAX ID #: SSN OR EIN	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ None

3. SECURED PARTY'S NAME (or NAME of TOTAL ASSIGNEE of ASSIGNOR S/P) – insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: RBS Citizens, National Association

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
63 Eugene O'Neill Drive	Hartford	CT	06103	USA

4. This FINANCING STATEMENT covers the following collateral:

The Debtor hereby grants to the Secured Party a security interest in the collateral described in Schedule A, attached hereto and made a part hereof.

5. ALTERNATIVE DESIGNATION [if applicable]: ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA
581355 CT SOS (Bond Loan)

FILING OFFICE COPY – NATIONAL UCC FINANCING STATEMENT (FORM UCC1) (REV. 07/29/98)
581355

FILING #0002791045 PG 02 OF 02 VOL U-00430
FILED 12/22/2010 12:00 PM PAGE 02180
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

SCHEDULE A TO

UCC FINANCING STATEMENT

(Secretary of the State – Gross Receipts)

Debtor: **THE WATERBURY HOSPITAL**
64 Robbins Street
Waterbury, CT 06708

Secured Party: RBS Citizens, National Association
63 Eugene O'Neill Drive
Hartford, CT 06103

Collateral: This financing statement covers the following properties, assets and rights of Debtor, wherever located, whether now owned or hereafter acquired or arising and all proceeds and products thereof:

(a) all Gross Receipts (as hereinafter defined) including, without limiting the generality of the foregoing, all rights to receive Gross Receipts whether in the form of accounts, accounts receivable, contract rights or other rights and to the proceeds of such rights; and

(b) all of Debtor's rights in and to all funds and accounts established and more particularly described, as the case may be, in that certain Loan Agreement (and Security Agreement) between the State of Connecticut Health and Educational Facilities Authority (**"CHEFA"**), Debtor and Secured Party dated as of December 1, 2010 ("Loan Agreement"), relating to the issuance of CHEFA's Revenue Bonds, Waterbury Hospital Issue, Series D (the **"Bonds"**).

For purposes hereof **"Gross Receipts"** means all receipts, revenues, income and other moneys received by or on behalf of the Debtor, including, but without limiting the generality of the foregoing, revenues derived from the ownership or operation of the properties and assets of the Debtor, including insurance and condemnation proceeds with respect to such properties and assets, or any portion thereof; and all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights, and the proceeds of such rights and whether now owned or held or hereafter coming into existence; **provided, however** that Gross Receipts shall not include (i) gifts, grants, bequests, donations and contributions heretofore or hereafter made and designated or specified by the granting authority, donor or maker thereof as being for specified purposes (other than payment of debt service on the Indebtedness (as that term is defined in the Loan Agreement) of the Debtor) and the income derived therefrom to the extent required by such designation or specification, and (ii) cash, cash equivalents, investment securities, endowment funds from time to time on hand with the Debtor, except to the extent derived from Gross Receipts after an Event of Default (as defined in the Loan Agreement).

[redacted]

FILING #0003067884 PG 01 OF 01 VOL U-00559
FILED 07/22/2015 08:30 AM PAGE 02408
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Corporation Service Company 1-800-858-5294

B. E-MAIL CONTACT AT FILER (optional)
SPRFiling@cscinfo.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

102415577 - 372200
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecticut (S.O.S.)

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE NUMBER
0002791045 12/22/2010

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS
Filer: attach Amendment Addendum (Form UCC3Ad) and provide Debtor's name in item 13

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to the security interest(s) of Secured Party authorizing this Termination Statement

3. ☐ ASSIGNMENT (full or partial): Provide name of Assignee in item 7a or 7b, and address of Assignee in item 7c and name of Assignor in item 9
For partial assignment, complete items 7 and 9 and also indicate affected collateral in item 8

4. ☑ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to the security interest(s) of Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law

5. ☐ PARTY INFORMATION CHANGE:

Check one of these two boxes:
This Change affects ☐ Debtor or ☐ Secured Party of record

AND Check one of these three boxes to:
☐ CHANGE name and/or address: Complete item 6a or 6b; and item 7a or 7b and item 7c
☐ ADD name: Complete item 7a or 7b, and item 7c
☐ DELETE name: Give record name to be deleted in item 6a or 6b

6. CURRENT RECORD INFORMATION: Complete for Party Information Change - provide only one name (6a or 6b)

6a. ORGANIZATION'S NAME THE WATERBURY HOSPITAL

OR

6b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

7. CHANGED OR ADDED INFORMATION: Complete for Assignment or Party Information Change - provide only one name (7a or 7b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name)

7a. ORGANIZATION'S NAME

OR

7b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

8. ☐ COLLATERAL CHANGE: Also check one of these four boxes: ☐ ADD collateral ☐ DELETE collateral ☐ RESTATE covered collateral ☐ ASSIGN collateral

Indicate collateral:

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT: Provide only one name (9a or 9b) (name of Assignor, if this is an Assignment)
If this is an Amendment authorized by a DEBTOR, check here ☐ and provide name of authorizing Debtor

9a. ORGANIZATION'S NAME Citizens Bank, N.A. Formally Known As RBS Citizens, N.A.

OR

9b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

10. OPTIONAL FILER REFERENCE DATA: Debtor: THE WATERBURY HOSPITAL
102415577

FILING OFFICE COPY — UCC FINANCING STATEMENT AMENDMENT (Form UCC3) (Rev. 04/20/11)

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

[redacted]

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Michelle Walters Fournier (860.240.2935)

B. E-MAIL CONTACT AT FILER (optional)
michelle.fournier@morganlewis.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michelle Walters Fournier
Senior Paralegal
Morgan, Lewis & Bockius LLP
One State Street
Hartford, CT 06103

FILING #0003087067 PG 01 OF 01 VOL U-00570
FILED 11/05/2015 08:30 AM PAGE 01082
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE NUMBER
0002791045

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS
Filer: attach Amendment Addendum (Form UCC3Ad) and provide Debtor's name in item 13

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to the security interest(s) of Secured Party authorizing this Termination Statement

3. ☐ ASSIGNMENT (full or partial): Provide name of Assignee in item 7a or 7b, and address of Assignee in item 7c and name of Assignor in item 9
For partial assignment, complete items 7 and 9 and also indicate affected collateral in item 8

4. ☐ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to the security interest(s) of Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law

5. ☑ PARTY INFORMATION CHANGE:

Check one of these two boxes: AND Check one of these three boxes to:

This Change affects ☐ Debtor or ☑ Secured Party of record

☑ CHANGE name and/or address: Complete item 6a or 6b; and item 7a or 7b and item 7c ☐ ADD name: Complete item 7a or 7b, and item 7c ☐ DELETE name: Give record name to be deleted in item 6a or 6b

6. CURRENT RECORD INFORMATION: Complete for Party Information Change - provide only one name (6a or 6b)

6a. ORGANIZATION'S NAME
RBS Citizens, National Association

OR

6b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

7. CHANGED OR ADDED INFORMATION: Complete for Assignment or Party Information Change - provide only one name (7a or 7b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name)

7a. ORGANIZATION'S NAME
Citizens Bank, National Association

OR

7b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
100 Sockanosset Cross Road, RDC395B	**Cranston**	**RI**	**02920**	**US**

8. ☐ COLLATERAL CHANGE: Also check one of these four boxes: ☐ ADD collateral ☐ DELETE collateral ☐ RESTATE covered collateral ☐ ASSIGN collateral

Indicate collateral:

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT: Provide only one name (9a or 9b) (name of Assignor, if this is an Assignment)
If this is an Amendment authorized by a DEBTOR, check here ☐ and provide name of authorizing Debtor

9a. ORGANIZATION'S NAME
CITIZENS BANK, NATIONAL ASSOCIATION (formerly known as RBS Citizens, National Association)

OR

9b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

10. OPTIONAL FILER REFERENCE DATA:
To be filed with the Secretary of the State of the State of Connecticut

[redacted]

FILING #0003094137 PG 01 OF 02 VOL U-00574
FILED 12/15/2015 08:30 AM PAGE 01244
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT AMENDM

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Michelle Walters Fournier (860.240.2935)

B. E-MAIL CONTACT AT FILER (optional)
michelle.fournier@morganlewis.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michelle Walters Fournier
Senior Paralegal
Morgan, Lewis & Bockius LLP
One State Street
Hartford, CT 06103

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE NUMBER
0002791045

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS
Filer: attach Amendment Addendum (Form UCC3Ad) and provide Debtor's name in item 13

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to the security interest(s) of Secured Party authorizing this Termination Statement

3. ☐ ASSIGNMENT (full or partial): Provide name of Assignee in item 7a or 7b, and address of Assignee in item 7c and name of Assignor in item 9
For partial assignment, complete items 7 and 9 and also indicate affected collateral in item 8

4. ☐ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to the security interest(s) of Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law

5. ☐ PARTY INFORMATION CHANGE:
Check one of these two boxes: AND Check one of these three boxes to:
This Change affects ☐ Debtor or ☐ Secured Party of record ☐ CHANGE name and/or address: Complete item 6a or 6b; and item 7a or 7b and item 7c ☐ ADD name: Complete item 7a or 7b, and item 7c ☐ DELETE name: Give record name to be deleted in item 6a or 6b

6. CURRENT RECORD INFORMATION: Complete for Party Information Change - provide only one name (6a or 6b)

6a. ORGANIZATION'S NAME
The Waterbury Hospital

OR

6b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

7. CHANGED OR ADDED INFORMATION: Complete for Assignment or Party Information Change - provide only one name (7a or 7b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name)

7a. ORGANIZATION'S NAME

OR

7b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

8. ☑ COLLATERAL CHANGE: Also check one of these four boxes: ☐ ADD collateral ☐ DELETE collateral ☑ RESTATE covered collateral ☐ ASSIGN collateral

Indicate collateral:

See Schedule A attached hereto and incorporated herein.

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT: Provide only one name (9a or 9b) (name of Assignor, if this is an Assignment)
If this is an Amendment authorized by a DEBTOR, check here ☐ and provide name of authorizing Debtor

9a. ORGANIZATION'S NAME
CITIZENS BANK, NATIONAL ASSOCIATION

OR

9b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

10. OPTIONAL FILER REFERENCE DATA:
To be filed with the Secretary of the State of the State of Connecticut

Additional Pages - 1

SCHEDULE A TO

UCC AMENDMENT

Debtor: THE WATERBURY HOSPITAL
64 Robbins Street
Waterbury, CT 06708

Secured Party: CITIZENS BANK, NATIONAL ASSOCIATION
100 Sockanosset Cross Road
RDC395B
Cranston, RI 02920

Collateral: This financing statement covers the following properties, assets and rights of Debtor, wherever located, whether now owned or hereafter acquired or arising and all proceeds and products thereof:

(a) all Gross Receipts (as hereinafter defined) including, without limiting the generality of the foregoing, all rights to receive Gross Receipts whether in the form of accounts, accounts receivable, contract rights or other rights and to the proceeds of such rights; and

(b) all of Debtor's rights in and to all funds and all accounts established in and more particularly described, as the case may be, in that certain Loan Agreement (and Security Agreement) between the State of Connecticut Health and Educational Facilities Authority ("**CHEFA**"), Debtor and Secured Party dated as of December 1, 2010, as amended by that certain Forbearance and Modification Agreement between Debtor and Secured Party dated December 7, 2015 (collectively, the "**Loan Agreement**"), relating to the issuance of CHEFA's Revenue Bonds, Waterbury Hospital Issue, Series D.

For purposes hereof "**Gross Receipts**" means all receipts, revenues, income, cash, cash equivalents and investment securities and other moneys received by or on behalf of the Debtor, including, but without limiting the generality of the foregoing, contributions, donations and pledges, whether in the form of cash, securities, or other personal property, revenues derived from the ownership or operation of the properties and assets of the Debtor, including insurance and condemnation proceeds with respect to such properties and assets or any portion thereof, and all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights, and the proceeds of such rights, and whether now owned or held or hereafter coming into existence; provided, however, that Gross Receipts shall not include gifts, grants, bequests, donations and contributions heretofore or hereafter made and designated or specified by the granting authority, donor or maker thereof as being for specified purposes (other than payment of debt service on the Indebtedness (as that term is defined in the Loan Agreement) of the Debtor) and the income derived therefrom to the extent required by such designation or specification or endowment funds or any other funds to the extent the granting of a security interest is prohibited by the terms of any agreement.

FILING #0003094137 PG 02 OF 02 VOL U-00574
FILED 12/15/2015 08:30 AM PAGE 01245
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

[redacted]

FILING #0002852974 PG 01 OF 01 VOL U-00453
FILED 12/29/2011 08:30 AM PAGE 02538
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]
Phone:(800) 331-3282 Fax: (818) 662-4141

B. SEND ACKNOWLEDGEMENT TO: (Name and Address) 11522 OLYMPUS AMERIC

CT Lien Solutions
P.O. Box 29071
Glendale, CA 91209-9071

31137177

CTCT

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (1a or 1b) - do not abbreviate or combine names

1a. ORGANIZATION'S NAME: WATERBURY HOSPITAL THE

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 ROBBINS STREET	WATERBURY	CT	06721	USA

1d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		NPC	CT	0267808 ☐ NONE

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (2a or 2b) - do not abbreviate or combine names

2a. ORGANIZATION'S NAME:

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ NONE

3. SECURED PARTY'S NAME (or NAME of TOTAL ASSIGNEE of ASSIGNOR S /P) - insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: Olympus America Inc.

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
3500 Corporate Parkway	Center Valley	PA	18034	USA

4. This FINANCING STATEMENT covers the following collateral:

OTV-S7PROH-HD-12E: New - VISERA PRO 20,500.00 High-Definition, autoclavable camera head, 1.2x, eye-piece type A7505A: New - Telescope, autoclavable, 30° direction of view, wide angle field of view, 1.9 x 65mm working length OEP-5: New - HD Olympus Printer LTF-VP: New - Deflectable EndoEYE laparo-thoraco videoscope, 5 mm diameter, 370 mm working length, 80° field of view, 18-100 mm depth of field LF-GP: New - PortaView Tracheal Intubation Fiberscope 5 5,709.00 BF-UC180F-O: New - Curvilinear array (CLA) ultrasound bronchofibervideoscope compatible with the EU-C60 ultrasound processor. Specifications include: 6.2 mm insertion tube outer diameter, 2.2 mm working channel, 60 cm working length, angulation range 120° (up) 90° (down), 80° field of view and 35° forward oblique direction of view. Ultrasound functions include: 7.5 MHz, B-mode, color power Doppler mode, 50° scanning range. Includes a detachable cable, MAJ-1722 for connection to the EU-C60. Complete with standard accessories. OEV-261H: New - OLYMPUS 26" FULL HD LCD MONITO WA03210A: New - Light guide 7 mm x 3 m autoclave without condenser, CF compatible WA50374B: New - Laparoscope, full screen, autoclavable, 45° direction of view, 5.4 x 300mm working length A4672A: New - A4672A MICROLAPAROSCOPE 3MM 0D AUTOCLAVABLE

5. ALTERNATIVE DESIGNATION [if applicable] ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA

31137177 0009612-004

FILING OFFICE COPY - NATIONAL UCC FINANCING STATEMENT (FORM UCC1) (REV. 05/22/02)

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

1:05p

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]

B. SEND ACKNOWLEDGMENT TO: (Name and Address) SG3

Corporation Service Company
801 ADLAI STEVENSON DRIVE
Springfield, IL 62703

2284057CT

299869-1

FILING #0002890181 PG 01 OF 01 VOL U-00468
FILED 08/03/2012 01:05 PM PAGE 00488
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (1a or 1b) - do not abbreviate or combine names

1a. ORGANIZATION'S NAME: WATERBURY HOSPITAL, THE

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 ROBBINS STREET	WATERBURY	CT	06708	USA

1d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		CORP	CT	0267808 ☐ NONE

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (2a or 2b) - do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ NONE

3. SECURED PARTY'S NAME (or NAME of TOTAL ASSIGNEE of ASSIGNOR S/P) - insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: JOHNSON & JOHNSON FINANCE CORPORATION

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
501 GEORGE ST	NEW BRUNSWICK	NJ	08901	USA

4. This FINANCING STATEMENT covers the following collateral:

All of Debtor's rights, title and interest of every kind now owned or hereafter acquired in and to the following: (1) EVOTECH EQUIPMENT KIT; CHEMCLEAN KIT; CHANNEL CONN TUBE; CONN BIOPSY, CHANNEL CONN TUBE-WHITE; YELLOW; BROWN; CHANNEL SEPARATOR; ADAPTER; STERRAD NX; STERRAD NX CART; CONNTUB INKIT 09601 / CONTRACT NUMBER 228405; (2) all accessories, upgrades, installations, accessions, appurtenances, component and replacement parts, tools, and additions to and substitutions for the foregoing; (3) all products and proceeds of the foregoing; (4) all renewals and replacements of the foregoing; and (5) all accounts, instruments, notes, chattel paper, documents, contract rights and general intangibles relating to or arising in connection with the foregoing.

5. ALTERNATIVE DESIGNATION (if applicable): ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA

CT-Secretary Of State

FILING OFFICE COPY — UCC FINANCING STATEMENT (FORM UCC1) (REV. 05/22/02)

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

STATE OF CONNECTICUT
UCC-1 FINANCING STATEMENT
Follow Instructions Carefully

Requesting Party
Name : CT LIEN
Address : 2727 ALLEN PARKWAY SUITE 1000
City : HOUSTON
State : TX
Country :
Zip : 77010

Fee $50.00 (Space for filing office use only)

FILING #0002912417 PG 1 OF 3
VOL 00477 PAGE 1325
FILED ON 12/24/2012 09:37 AM
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR NAMES AND ADDRESSES:

BUSINESS NAME : THE WATERBURY HOSPITAL
TYPE OF ORGANIZATION : CORPORATION
JURISDICTION OF ORGANIZATION : CT
ADDRESS1 : 64 ROBBINS STREET
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : WATERBURY , CT 06708
COUNTRY :

2. SECURED PARTY NAMES AND ADDRESSES:

BUSINESS NAME : ALLEGHENY VALLEY BANK OF PITTSBURGH
ADDRESS1 : 5137 BUTLER STREET
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : PITTSBURGH , PA 15201
COUNTRY :

3. ASSIGNOR NAMES AND ADDRESSES:

NONE

FILING #0002912417 PG 2 OF 3
VOL 00477 PAGE 1326
FILED ON 12/24/2012 09:37 AM
CONNECTICUT SECRETARY OF THE STATE

4. This FINANCING STATEMENT covers the following collateral:

AcuDose-RX Remote Refrigerator locks 7 8 drwr Auxilliary 2 Fast Entry Biometrics 3 1/2 Height Detecting Drawers 6 1/2 High Capacity Locking Drawers 20 8 drwr Main-Non-Profile 4 4 drwr Supply Tower 4 Bar Code Scanner 3 Bar Code Scanner Base 3 CarePoint Connect Software License 1 Implementation 1 Horizon MedComm Backbone HW (Standard Vol. Standalone) 1 Fax Server (08 Channel) (to utilize existing fax servers) 1 Order Review Hardware in Pharmacy 4 Order Review SW in Pharmacy (Local) 4 Order Review SW (Remote) 5 MedComm SW license 1 Implementation PIS Linking 9 Implementation 1 MedCarousel MedCarousel Implementation 1 Packaging Solutions PacMed Robot Ready 1 Tadpole Printer 1 PacMed Implementation 1 FulFill-RX FulFill-Rx Software License 1 Cyclone Software License 1 Implementation 1

FILING #0002912417 PG 3 OF 3
VOL 00477 PAGE 1327
FILED ON 12/24/2012 09:37 AM
CONNECTICUT SECRETARY OF THE STATE

5. ALTERNATIVE DESIGNATION (if applicable) :

- ☐ LESSEE/LESSOR
- ☐ CONSIGNEE/CONSIGNOR
- ☐ BAILEE/BAILOR
- ☐ SELLER/BUYER
- ☒ NONE

6. DEBTOR IS (if applicable) :

- ☐ TRUST
- ☐ TRUSTEE ACTING WITH RESPECT TO PROPERTY HELD IN TRUST
- ☐ DESCENDANT'S ESTATE
- ☒ NONE

7. Check only if applicable :

- ☐ Debtor is a TRANSMITTING UTILITY
- ☐ Filed in connection with Public Finance Transaction
- ☒ NONE

8. OPTIONAL FILER REFERENCE DATA :
CT-0-36297036

SECRETARY OF THE STATE OF CONNECTICUT

MAILING ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, P.O. BOX 150470, HARTFORD, CT 06115-0470
DELIVERY ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, 30 TRINITY STREET, HARTFORD, CT 06106
PHONE: 860-509-6002 WEBSITE: www.concord-sots.ct.gov

STATE OF CONNECTICUT
UCC-1 FINANCING STATEMENT

USE INK. COMPLETE ALL SECTIONS. PRINT OR TYPE. ATTACH 81/

FILING #0002951331 PG 01 OF 03 VOL U-00496
FILED 08/05/2013 02:28 PM PAGE 02479
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

FILING PARTY *(CONFIRMATION WILL BE SENT TO THIS ADDRE*

CUSTOMER ID:

NAME: Webster Bank, National Association

ADDRESS: 185 Asylum Street

Attention: Comm'l Healthcare Lending

CITY: Hartford

STATE: CT ZIP: 06103

EMAIL:

OF THE STATE"

1. DEBTOR'S EXACT FULL LEGAL NAME - *INSERT ONLY ONE DEBTOR NAME (1A OR 1B) - DO NOT ABBREVIATE OR COMBINE NAMES*

1A. ORGANIZATION'S NAME

THE WATERBURY HOSPITAL

OR

1B. INDIVIDUAL'S

SURNAME

FIRST PERSONAL NAME | MIDDLE | SUFFIX

1C. MAILING ADDRESS:

ADDRESS: 64 ROBBINS STREET

CITY: WATERBURY

STATE: CT ZIP: 06708 COUNTRY: USA

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME - *INSERT ONLY ONE DEBTOR NAME (2A OR 2B) - DO NOT ABBREVIATE OR COMBINE NAMES*

2A. ORGANIZATION'S NAME

OR

2B. INDIVIDUAL'S

SURNAME

FIRST PERSONAL NAME | MIDDLE | SUFFIX

2C. MAILING ADDRESS:

ADDRESS:

CITY:

STATE: ZIP: COUNTRY:

3. SECURED PARTY NAME (OR NAME OF ASSIGNEE OF ASSIGNOR S/P) - *INSERT ONLY ONE SECURED PARTY NAME (3A OR 3B)*

	3A. ORGANIZATION'S NAME		
OR	WEBSTER BANK, NATIONAL ASSOCIATION		
	3B. INDIVIDUAL'S		
	SURNAME		
	FIRST PERSONAL NAME	MIDDLE	SUFFIX

3C. MAILING ADDRESS:

ADDRESS: 185 Asylum Street

CITY: Hartford

STATE: CT ZIP: 06103 COUNTRY: USA

4. THIS FINANCING STATEMENT COVERS THE FOLLOWING COLLATERAL:

All assets of the Debtor described on Exhibit A attached hereto

5. CHECK ONLY IF APPLICABLE AND CHECK ONLY ONE BOX: COLLATERAL IS ☐ HELD IN A TRUST (SEE UCC 1AD, ITEM 13 AND INSTRUCTIONS) ☐ BEING ADMINISTERED BY A DECENDENT'S PERSONAL REPRESENTATIVE.

6. CHECK ONLY IF APPLICABLE AND CHECK ONLY ONE BOX:

☐ **Public-Finance Transaction** ☐ **A Debtor is a Transmitting Utility**

7. ALTERNATIVE DESIGNATION *(if applicable):*

☐ **Lessee / Lessor** ☐ **Consignee / Consignor** ☐ **Seller / Buyer** ☐ **Bailee / Bailor** ☐ **Licensee / Licensor**

8. OPTIONAL FILER REFERENCE DATA:

FILING #0002951331 PG 02 OF 03 VOL U-00496
FILED 08/05/2013 02:28 PM PAGE 02480
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

EXHIBIT A

DEBTOR:

THE WATERBURY HOSPITAL
64 Robbins Street
Waterbury, CT 06708

SECURED PARTY:

WEBSTER BANK
145 Bank Street
Waterbury, CT 06702

All right, title and interest of the Debtor in and to the Money Market Account (the "Account") identified as follows:

Webster Bank Certificate of Deposit

Number: 10105347659

Amount: $1,000,000

Date Opened: July 30, 2013

Maturity Date: July 30, 2014

and all interest due or to become due on said Account, and all proceeds thereof, including, without limitation, all other Investment Property, Accounts, Deposit Accounts, Certificates of Deposit, Letter of Credit Rights and/or General Intangibles, and all Supporting Obligations relating thereto which may now or hereafter constitute Proceeds (as each such capitalized term is defined in the Uniform Commercial Code as in effect in Connecticut, as may be amended from time to time) of said Certificate of Deposit and each and every new Account, Deposit Account, Certificate of Deposit or other Investment Property which may be issued to the undersigned in renewal or replacement of the aforementioned Certificate of Deposit (herein the "Collateral").

FILING #0002951331 PG 03 OF 03 VOL U-00496
FILED 08/05/2013 02:28 PM PAGE 02481
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

SECRETARY OF THE STATE OF CONNECTICUT
UCC-1 FINANCING STATEMENT

FILING #0002969025 PG 1 OF 3
VOL 00506 PAGE 0235
FILED ON 12/04/2013 01:19 PM
SECRETARY OF THE STATE OF CONNECTICUT

1. DEBTOR NAMES AND ADDRESSES:

BUSINESS NAME : WATERBURY HOSPITAL THE
ADDRESS1 : 64 ROBBINS STREET
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : WATERBURY , CT 06721
COUNTRY :

2. SECURED PARTY NAMES AND ADDRESSES:

BUSINESS NAME : OLYMPUS AMERICA INC.
ADDRESS1 : 3500 CORPORATE PARKWAY
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : CENTER VALLEY , PA 18034
COUNTRY :

3. ASSIGNOR NAMES AND ADDRESSES:

NONE

4. This FINANCING STATEMENT covers the following collateral:

Seller/Supplier: Olympus America Inc. Quote Number: 187026-10 Quantity Model Number Description Five (5) CF-HQ190L CF-HQ190L EVIS EXERA III HD COLONOSCOPE DUAL FOC SCPEGDE Six (6) PCF-H190L PCF-H190L EVIS EXERA III HD PEDIATRIC COLONOSCOPE Five (5) GIF-HQ190 GIF-HQ190 EVIS EXERA III HIGH DEFINITION DUAL FOCUSGASTROSCO One (1) TJF-Q180V VIDEO DUODENOSCOPE W/NBI, IMPROVED GUIDEWIRE LOCKING Five (5) CV-190 CV-190 EVIS EXERA III VIDEO PROCESSOR Five (5) CLV-190 CLV-190 EVIS EXERA III LIGHT SOURCE Five (5) MAJ-1430 MAJ-1430 VIDEOSCOPE CABLE EVIS EXERA II Five (5) MAJ-1916 MAJ-1916 CV INTERFACE CONVERTE DEVICE Five (5) MAJ-1918 MAJ-1918 REMOTE CABLE PERIPHER AL DEVICE 1.8M One (1) OEV-261H OLYMPUS 26 FULL HD LCD MONITOR One (1) OL-0015-07 GCX HD ROLLSTAND 47-61.5 23- 32# W/PWR SUP HOLSTER & CORD-W One (1) OL-0015-25 GCX ROLLSTAND AC ADAPTER KIT FOR OEV-261H One (1) OFP-2 OFP-2 FLUSHING PUMP One (1) MH-984 MH-984 RGB PRINTER CABLE FOR C V-160 RGB CABLE FOR OTV-S5C One (1) MAJ-854 MAJ-854 REMOTE CABLE CV-160 FOR SVR PRINTER One (1) OEP-4 OEP-4 OLYMPUS COLOR PRINTER Consumable Products: Seller/Supplier: Olympus America Inc. Quote Number: 187026-10 Quantity Model Number Description Five (5) G-240-2545S VISIGLIDE GUIDEWIRE .025, 450 CM, STRAIGHT TIP Five (5) G-240-3545S VISIGLIDE GUIDEWIRE .035, 450 CM, STRAIGHT TIP Five (5) B-V233P-A MULTI-3V PLUS 15 MM, OVER THE WIRE, ABOVE INJECTION Five (5) B-V243Q-A MULTI-3V PLUS 15 MM, DISTALLY WIREUIDED ABOVE INJECTION Five (5) BC-V600P-3010 BRUSHMASTER V CYTOLOGY BRUSH Five (5) KD-V411M-0725 CLEVERCUT3-V TRPL LUM SPHINCT 7MM TIP 25MM WIRE V-SYSTEM Five (5) KD-V431M-0720 CLEVERCUT3-V TRPL LUM TAPERED SPHINCT 7MM TIP 20MM WIRE V Five (5) FG-V421PR FLOWERBASKETV ROTATABLE RETRIEVAL BASKET, 8 WIRE Five (5) FG-V431P FLOWERBASKETV WIREGUIDED RETRIEVAL BASKET, 8 WIRE One (1) MAJ-441 LITHOCRSH V HNDL AUTOCLVABLE BML-V232/242/442QR Three (3) BML-V442QR-30 LITHOCRSH V WIRGUID LITHOTRIPT 30MM ROTBSKT 4.2MM CHNL DISP Seller/Supplier: Olympus America Inc. Rollover Equipment From Master Agreement Number 009612 (CPP Schedule 003) Quantity Model Number Description Serial Number One (1) OEP-4 OLYMPUS COLOR PRINTER A107234 One (1) GIF-1TQ160 THERAPEUTIC VIDEO GASTROSCOPE 2002193 Three (3) OEV-191H LCD HD TV FLAT PANEL MONITOR 7820184, 7820225, 7820289 One (1) FLP-0008-02 TABLE TOP STAND And all substitutions, replacements, additions, attachments & accessories thereto and proceeds thereof, now owned or hereafter acquired. This financing statement is filed for notice purposes only & the filing thereof shall not be deemed evidence of any intention to create a security interest under the Uniform Commercial Code.

FILING #0002969025 PG 3 OF 3
VOL 00506 PAGE 0237
FILED ON 12/04/2013 01:19 PM
SECRETARY OF THE STATE OF CONNECTICUT

5. ALTERNATIVE DESIGNATION (if applicable) :

- ☐ LESSEE/LESSOR
- ☐ CONSIGNEE/CONSIGNOR
- ☐ BAILEE/BAILOR
- ☐ SELLER/BUYER
- ☒ NONE

6. DEBTOR IS (if applicable) :

- ☐ TRUST
- ☐ TRUSTEE ACTING WITH RESPECT TO PROPERTY HELD IN TRUST
- ☐ DESCENDANT'S ESTATE
- ☒ NONE

7. Check only if applicable :

- ☐ Debtor is a TRANSMITTING UTILITY
- ☐ Filed in connection with Public Finance Transaction
- ☒ NONE

8. OPTIONAL FILER REFERENCE DATA :

CT-0-40889843

[redacted]

FILING #0003015083 PG 01 OF 01 VOL U-00530
FILED 09/11/2014 08:30 AM PAGE 02680
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Corporation Service Company 1-800-858-5294

B. E-MAIL CONTACT AT FILER (optional)
SPRFiling@cscinfo.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

90812284 - 346290
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecticut (S.O.S.)

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME: The Waterbury Hospital

OR

1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 Robbins Street	Waterbury	CT	06708	USA

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME: Mazuma Capital Corp

OR

3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
12257 Business Park Drive, Suite 225	Draper	UT	84020	USA

4. COLLATERAL: This financing statement covers the following collateral:

Medical equipment including but not limited to ultrasounds, imaging equipment and related software, pumps, monitors, lasers, C-arms, medical facility furnishings and other items of Property purchased or paid for by Mazuma Capital Corp and leased to Lessee under Lease Schedule No. 43-01 to Master Lease Agreement No. MCC1320 between The Waterbury Hospital, as Lessee and Mazuma Capital Corp, as Lessor, and any and all attachments, accessions, additions, enhancements and replacements thereto, and insurance, lease, sublease and other proceeds thereof.

THIS IS A "TRUE LEASE". FILING IS FOR INFORMATIONAL PURPOSES ONLY. THE PARTIES DO NOT BELIEVE THE LEASE IS SUBJECT TO UCC9. THE PROPERTY IS OWNED BY LESSOR AND LEASED TO LESSEE. LESSEE DOES NOT HAVE THE RIGHT TO SELL OR PLEDGE THE PROPERTY.

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☑ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA: :MCC1320-43-01-KA

90812284

FILING OFFICE COPY — UCC FINANCING STATEMENT (Form UCC1) (Rev. 04/20/11)

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

SECRETARY OF THE STATE OF CONNECTICUT
UCC-3 FINANCING STATEMENT AMENDMENT

FILING #0003028590 PG 1 OF 2
VOL 00538 PAGE 1609
FILED ON 11/24/2014 01:00 PM
SECRETARY OF THE STATE OF CONNECTICUT

1. INITIAL FINANCING STATEMENT FILE # :

0003015083

2. ☐ **TERMINATION:** Effectiveness of the Financing Statement identified above is terminated with respect to security interest(s) of the secured party authorizing this termination statement.

3. ☐ **CONTINUATION:** Effectiveness of the Financing Statement identified above with respect to security interest(s) of the secured party authorizing this continuation statement is continued for the additional period provided by applicable law.

4. ■ **ASSIGNMENT(full or partial):** Give name of assignor at point 7.

5. ☐ **AMENDMENT(PARTY INFORMATION) :**

5.1 This Amendment Affects :

☐ Debtor ☐ Secured Party

☐ Added ☐ Deleted ☐ Change

6. ☐ **AMENDMENT (COLLATERAL CHANGE):** (Check only one box)

☐ Added ☐ Deleted ☐ Restated ☐ Assigned

7. NAME OF PARTY OF RECORD AUTHORIZING THIS AMENDMENT : ((name of assignor, if this is an Assignment). If this is an Amendment authorized by a Debtor which adds collateral or adds the authorizing Debtor, or if this is a Termination authorized by a Debtor). ☐

MAZUMA CAPITAL CORP

8. OPTIONAL FILER REFERENCE DATA :

FILING #0003028590 PG 2 OF 2
VOL 00538 PAGE 1610
FILED ON 11/24/2014 01:00 PM
SECRETARY OF THE STATE OF CONNECTICUT

9. ASSIGNEE NAMES AND ADDRESSES:

BUSINESS NAME : TRANSPORTATION ALLIANCE BANK INC.
ADDRESS1 : 4185 SOUTH HARRISON BLVD., SUITE 200
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : OGDEN , UT 84403
COUNTRY :

SECRETARY OF THE STATE OF CONNECTICUT
UCC-3 FINANCING STATEMENT AMENDMENT

FILING #0003079617 PG 1 OF 2
VOL 00566 PAGE 0223
FILED ON 09/30/2015 02:53 PM
SECRETARY OF THE STATE OF CONNECTICUT

1. INITIAL FINANCING STATEMENT FILE # :

0003015083

2. ☐ **TERMINATION:** Effectiveness of the Financing Statement identified above is terminated with respect to security interest(s) of the secured party authorizing this termination statement.

3. ☐ **CONTINUATION:** Effectiveness of the Financing Statement identified above with respect to security interest(s) of the secured party authorizing this continuation statement is continued for the additional period provided by applicable law.

4. ■ **ASSIGNMENT(full or partial):** Give name of assignor at point 7.

5. ☐ **AMENDMENT(PARTY INFORMATION) :**

5.1 This Amendment Affects :

☐ Debtor ☐ Secured Party

☐ Added ☐ Deleted ☐ Change

6. ☐ **AMENDMENT (COLLATERAL CHANGE):** (Check only one box)

☐ Added ☐ Deleted ☐ Restated ☐ Assigned

7. NAME OF PARTY OF RECORD AUTHORIZING THIS AMENDMENT : ((name of assignor, if this is an Assignment). If this is an Amendment authorized by a Debtor which adds collateral or adds the authorizing Debtor, or if this is a Termination authorized by a Debtor). ☐

TRANSPORTATION ALLIANCE BANK INC.

8. OPTIONAL FILER REFERENCE DATA :

FILING **#0003079617** PG **2** OF **2**
VOL **00566** PAGE **0224**
FILED ON **09/30/2015 02:53 PM**
SECRETARY OF THE STATE OF CONNECTICUT

9. ASSIGNEE NAMES AND ADDRESSES:

BUSINESS NAME : PRIME ALLIANCE BANK, INC.
ADDRESS1 : 1868 S. 500 W.
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : WOODS CROSS , UT 84087
COUNTRY :

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Corporation Service Company 1-800-858-5294

B. E-MAIL CONTACT AT FILER (optional)
SPRFiling@cscinfo.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

92770926 - 346290
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecti
(S.O.

FILING #0003025143 PG 01 OF 01 VOL U-00536
FILED 10/31/2014 08:30 AM PAGE 01865
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME: The Waterbury Hospital

OR

1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 Robbins Street	Waterbury	CT	06708	USA

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME: Mazuma Capital Corp

OR

3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
13997 South Minuteman Drive, Suite 200	Draper	UT	84020	USA

4. COLLATERAL: This financing statement covers the following collateral:

Medical equipment including but not limited to ultrasounds, imaging equipment and related software, pumps, monitors, laser, C-arms, medical facility furnishings and other items of Property purchased or paid for by Mazuma Capital Corp and leased to Lessee under Lease Schedule No. 44-02 to Master Lease Agreement No. MCC1320 between The Waterbury Hospital, as Lessee and Mazuma Capital Corp, as Lessor, and any and all attachments, accessions, additions, enhancements and replacements thereto, and insurance, lease, sublease and other proceeds thereof.

THIS IS A "TRUE LEASE". FILING IS FOR INFORMATIONAL PURPOSES ONLY. THE PARTIES DO NOT BELIEVE THE LEASE IS SUBJECT TO UCC9. THE PROPERTY IS OWNED BY LESSOR AND LEASED TO LESSEE. LESSEE DOES NOT HAVE THE RIGHT TO SELL OR PLEDGE THE PROPERTY.

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and Instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☑ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA: :1320-4402-KA

92770926

[redacted]

FILING #0003047052 PG 01 OF 02 VOL U-00547
FILED 04/01/2015 08:30 AM PAGE 03578
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Phone: (800) 331-3282 Fax: (818) 662-4141

B. E-MAIL CONTACT AT FILER (optional)
CLS-CTLS_Glendale_Customer_Service@wolterskluwer.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address) 13052 - Element Financial

CT Lien Solutions
P.O. Box 29071
Glendale, CA 91209-9071

47377591
CTCT

File with: Secretary of State, CT

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME
WATERBURY HOSPITAL THE

OR

1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 Robbins Street	Watrebury	CT	06708	USA

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME
ELEMENT FINANCIAL CORP.

OR

3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
655 Business Center Drive	Horsham	PA	19044	USA

4. COLLATERAL: This financing statement covers the following collateral:
All Equipment listed on Schedule A together with all proceeds from sale or disposition thereof, all proceeds of insurance thereon, all substitutions therefore and all additions thereto.

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and Instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☒ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA:
47377591 133290

FILING OFFICE COPY — UCC FINANCING STATEMENT (Form UCC1) (Rev. 04/20/11)

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

Schedule A

FILING #0003047052 PG 02 OF 02 VOL U-00547
FILED 04/01/2015 08:30 AM PAGE 03579
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

TJ1641 WBG4500CARMAI	GOLD SOFTWARE SUPPORT & ADVANCED RMA HARDWARE SUPPORT EXTENDED SERVICE AGREEMENT - REPLACEMENT - 1 YEAR - SHIPMENT - RESPONSE TIME: SBD - GHE - ASSOCIATE - FOR P/N: WBG-4500-CI HW Warranty	2
TJ1641 WBG4500CARMAI	GOLD SOFTWARE SUPPORT & ADVANCED RMA HARDWARE SUPPORT EXTENDED SERVICE AGREEMENT - REPLACEMENT - 1 YEAR - SHIPMENT - RESPONSE TIME: SBD - GHE - ASSOCIATE - FOR P/N: WBG-4500-CI HW Warranty	2
FN8994 WRPCKE-AA-GI	MCAFEE WEB REPORTER PREMIUM, GATEWAY EDITION SOFTWARE STANDARD OFFERING - PERPETUAL LICENSE WITH 1YR MCAFEE GOLD SOFTWARE SUPPORT - 1001-2000 NODES E-CERTIFICATE GHE-levelG-LSA	1001
FN9003 WRPYCM-AA-GI	MCAFEE WEB REPORTER PREMIUM, GATEWAY EDITION SOFTWARE STANDARD OFFERING - 1YR GOLD SOFTWARE SUPPORT - 1001-2000 NODES E-CERTIFICATE GHE-levelG-SA	1001
FN9003 WRPYCM-AA-GI	MCAFEE WEB REPORTER PREMIUM, GATEWAY EDITION SOFTWARE STANDARD OFFERING - 1YR GOLD SOFTWARE SUPPORT - 1001-2000 NODES E-CERTIFICATE GHE-levelG-SA	1001
HH7415 PENYDM-AT-AI	PLATINUM TECHNICAL SUPPORT ENTERPRISE 1YR GOLD SOFTWARE SUPPORT - 1+ NODES E-CERTIFICATE GHE-levelA-SA	1
HH7415 PENYDM-AT-AI	PLATINUM TECHNICAL SUPPORT ENTERPRISE 1YR GOLD SOFTWARE SUPPORT - 1+ NODES E-CERTIFICATE GHE-levelA-SA	1
HH7415 PENYDM-AT-AI	PLATINUM TECHNICAL SUPPORT ENTERPRISE 1YR GOLD SOFTWARE SUPPORT - 1+ NODES E-CERTIFICATE GHE-levelA-SA	1
TH8592 EMG-4500-CI	MCAFEE EMAIL GATEWAY SECURITY APPLIANCE SECURITY APPLIANCE - 10MB LAN, 100MB LAN, GIGE - 1U - GHE - ASSOCIATE - RACK-MOUNTABLE	2
TT1534 EMG4500CARMAI	GOLD SOFTWARE SUPPORT & ADVANCED RMA HARDWARE SUPPORT EXTENDED SERVICE AGREEMENT - REPLACEMENT - 1 YEAR - SHIPMENT - RESPONSE TIME: SBD - GHE - ASSOCIATE - FOR P/N: EMG-4500-CI HW Warranty	2
TT1534 EMG4500CARMAI	GOLD SOFTWARE SUPPORT & ADVANCED RMA HARDWARE SUPPORT EXTENDED SERVICE AGREEMENT - REPLACEMENT - 1 YEAR - SHIPMENT - RESPONSE TIME: SBD - GHE - ASSOCIATE - FOR P/N: EMG-4500-CI HW Warranty	2
TT1534 EMG4500CARMAI	GOLD SOFTWARE SUPPORT & ADVANCED RMA HARDWARE SUPPORT EXTENDED SERVICE AGREEMENT - REPLACEMENT - 1 YEAR - SHIPMENT - RESPONSE TIME: SBD - GHE - ASSOCIATE - FOR P/N: EMG-4500-CI HW Warranty	2
MQ3659 MFEFOCUSEBI	MCAFEE FOCUS PASS EARLY BIRD - (PASS NO SUPPORT) GENERAL ITEM - STANDARD OFFERING E-DOWNLOAD Lic	8
NJ7005 TRN-SITE4A	SOLUTION SERVICES LECTURES AND LABS - 4 DAYS - ON-SITE (PROMOTIONAL)	1

Remit To:

SoftChoice Corporation
16609 Collections Center Drive

Chicago, IL 60693
Accounting Tel (888) 549-7638
Accounting Fax (888) 549-7639
Sales Tel (800) 268-7638

This invoice and the transaction to which it pertains are governed by the terms and conditions set out

v1.6

SECRETARY OF THE STATE OF CONNECTICUT
UCC-1 FINANCING STATEMENT

FILING **#0003074593** PG **1** OF **5**
VOL **00563** PAGE **1360**
FILED ON **09/02/2015 09:45 AM**
SECRETARY OF THE STATE OF CONNECTICUT

1. DEBTOR NAMES AND ADDRESSES:

BUSINESS NAME : WATERBURY HOSP
ADDRESS1 : 64 ROBBINS ST
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : WATERBURY , CT 06708
COUNTRY :

2. SECURED PARTY NAMES AND ADDRESSES:

BUSINESS NAME : BAXTER HEALTHCARE CORPORATION
ADDRESS1 : ONE BAXTER PARKWAY
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : DEERFIELD , IL 60015
COUNTRY :

3. ASSIGNOR NAMES AND ADDRESSES:

NONE

4. This FINANCING STATEMENT covers the following collateral:

Asset(s)listed below: 35700BAX2 2010178 35700BAX2 2010333 35700BAX2 2013001 35700BAX2 2014085 35700BAX2 2014095 35700BAX2 2014097 35700BAX2 2014207 35700BAX2 2014408 35700BAX2 2014766 35700BAX2 2015365 35700BAX2 2015505 35700BAX2 2015563 35700BAX2 2016016 35700BAX2 2016439 35700BAX2 2017368 35700BAX2 2018146 35700BAX2 2018147 35700BAX2 2018307 35700BAX2 2018641 35700BAX2 2019152 35700BAX2 2019250 35700BAX2 2019279 35700BAX2 2019680 35700BAX2 2019874 35700BAX2 2019880 35700BAX2 2019961 35700BAX2 2020343 35700BAX2 2020981 35700BAX2 2021151 35700BAX2 2021276 35700BAX2 2021444 35700BAX2 2022441 35700BAX2 2022596 35700BAX2 2022606 35700BAX2 2022720 35700BAX2 2023453 35700BAX2 2023484 35700BAX2 2023485 35700BAX2 2023684 35700BAX2 2023750 35700BAX2 2023921 35700BAX2 2023969 35700BAX2 2024050 35700BAX2 2024343 35700BAX2 2025415 35700BAX2 2025612 35700BAX2 2025999 35700BAX2 2027227 35700BAX2 2027368 35700BAX2 2027788 35700BAX2 2028100 35700BAX2 2028839 35700BAX2 2029144 35700BAX2 2029788 35700BAX2 2029796 35700BAX2 2030515 35700BAX2 2030908 35700BAX2 2031017 35700BAX2 2031046 35700BAX2 2031050 35700BAX2 2031056 35700BAX2 2031098 35700BAX2 2031143 35700BAX2 2031303 35700BAX2 2031351 35700BAX2 2031756 35700BAX2 2031946 35700BAX2 2032117 35700BAX2 2032172 35700BAX2 2032216 35700BAX2 2032369 35700BAX2 2032502 35700BAX2 2032506 35700BAX2 2032619 35700BAX2 2032728 35700BAX2 2032871 35700BAX2 2032898 35700BAX2 2032934 35700BAX2 2033223 35700BAX2 2033375 35700BAX2 2033389 35700BAX2 2033549 35700BAX2 2033989 35700BAX2 2034329 35700BAX2 2034541 35700BAX2 2035003 35700BAX2 2035485 35700BAX2 2035771 35700BAX2 2035907 35700BAX2 2036017 35700BAX2 2036021 35700BAX2 2036071 35700BAX2 2036084 35700BAX2 2036352 35700BAX2 2036422 35700BAX2 2036458 35700BAX2 2036572 35700BAX2 2036605 35700BAX2 2036634 35700BAX2 2036648 35700BAX2 2036762 35700BAX2 2036796 35700BAX2 2036829 35700BAX2 2036883 35700BAX2 2036954 35700BAX2 2037031 35700BAX2 2037035 35700BAX2 2037091 35700BAX2 2037171 35700BAX2 2037175 35700BAX2 2037261 35700BAX2 2037301 35700BAX2 2037395 35700BAX2 2037462 35700BAX2 2037480 35700BAX2 2037534 35700BAX2 2037537 35700BAX2 2037662 35700BAX2 2037671 35700BAX2 2037726 35700BAX2 2037823 35700BAX2 2037835 35700BAX2 2037846 35700BAX2 2037904 35700BAX2 2037940 35700BAX2 2037943 35700BAX2 2038106 35700BAX2 2038141 35700BAX2 2038177 35700BAX2 2038450 35700BAX2 2038454 35700BAX2 2038553 35700BAX2 2039430 35700BAX2 2039477 35700BAX2 2039493 35700BAX2 2039522 35700BAX2 2039598 35700BAX2 2039648 35700BAX2 2039677 35700BAX2 2039738 35700BAX2 2039785 35700BAX2 2039810 35700BAX2 2039869 35700BAX2 2039897 35700BAX2 2039913 35700BAX2 2040032 35700BAX2 2040143 35700BAX2 2040204 35700BAX2 2040235 35700BAX2 2040239 35700BAX2 2040248 35700BAX2 2040296 35700BAX2 2040309 35700BAX2 2040353 35700BAX2 2040355 35700BAX2 2040368 35700BAX2 2040373 35700BAX2 2040385 35700BAX2 2040400 35700BAX2 2040412 35700BAX2 2040436 35700BAX2 2040446 35700BAX2 2040451 35700BAX2 2040478 35700BAX2 2040504 35700BAX2 2040520 35700BAX2 2040525 35700BAX2 2040553 35700BAX2 2040622 35700BAX2 2040625 35700BAX2 2040669 35700BAX2 2040683 35700BAX2 2040704 35700BAX2 2040711 35700BAX2 2040713 35700BAX2 2040746 35700BAX2 2040781 35700BAX2 2040786 35700BAX2 2040800 35700BAX2 2040816 35700BAX2 2040820 35700BAX2 2040829 35700BAX2 2040838 35700BAX2 2040846 35700BAX2 2040868 35700BAX2 2040871 35700BAX2 2040915 35700BAX2 2040954 35700BAX2 2040958 35700BAX2 2040969 35700BAX2 2040971 35700BAX2 2041003 35700BAX2 2041004 35700BAX2 2041008 35700BAX2 2041009 35700BAX2 2041034 35700BAX2 2041035 35700BAX2 2041046 35700BAX2 2041047 35700BAX2 2041055 35700BAX2 2041083 35700BAX2 2041093 35700BAX2 2041102 35700BAX2 2041108 35700BAX2 2041112 35700BAX2 2041123 35700BAX2 2041135 35700BAX2 2041200 35700BAX2 2041204 35700BAX2 2041206 35700BAX2 2041248 35700BAX2 2041261 35700BAX2 2041304 35700BAX2 2041314 35700BAX2 2041334 35700BAX2 2041340 35700BAX2 2041357 35700BAX2 2041367 35700BAX2 2041379 35700BAX2 2041444 35700BAX2 2041457 35700BAX2 2041458 35700BAX2 2041465 35700BAX2 2041466 35700BAX2 2041476 35700BAX2 2041513 35700BAX2 2041522 35700BAX2 2041530 35700BAX2 2041540 35700BAX2 2041572 35700BAX2 2041595 35700BAX2 2041604 35700BAX2 2041611 35700BAX2 2041613 35700BAX2 2041621 35700BAX2 2041622 35700BAX2 2041943 35700BAX2 20

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41975 35700BAX2 2041980 35700BAX2 2041983 35700BAX2 2041985 35700BAX2 2041993 35700BAX2 2041997 35700BAX2 2042000 35700BAX2 2042002 35700BAX2 2042004 35700BAX2 2042010 35700BAX2 2042031 35700BAX2 2042033 35700BAX2 2042051 35700BAX2 2042092 35700BAX2 2042097 35700BAX2 2042102 35700BAX2 2042117 35700BAX2 2042148 35700BAX2 2042158 35700BAX2 2042162 35700BAX2 2042165 35700BAX2 2042185 35700BAX2 2042188 35700BAX2 2042191 35700BAX2 2042197 35700BAX2 2042437 35700BAX2 2042457 35700BAX2 2042537 35700BAX2 2042647 35700BAX2 2042657 35700BAX2 2042698 35700BAX2 2042714 35700BAX2 2042717 35700BAX2 2042731 35700BAX2 2042750 35162 00409D5A1E05 35162 00409D63461C 35162 00409D634622 35162 00409D634623 35162 00409D634625 35162 00409D634626 35162 00409D63462C 35162 00409D634637 35162 00409D63463D 35162 00409D634643 35162 00409D634646 35162 00409D63464E 35162 00409D634668 35162 00409D634672 35162 00409D634673 35162 00409D634674 35162 00409D634677 35162 00409D634679 35162 00409D63467A 35162 00409D63467B 35162 00409D63467E 35162 00409D634681 35162 00409D634682 35162 00409D634683 35162 00409D634685 35162 00409D634686 35162 00409D634687 35162 00409D634689 35162 00409D63468B 35162 00409D63468C 35162 00409D634691 35162 00409D634696 35162 00409D634699 35162 00409D634A1E 35162 00409D634A20 35162 00409D634A21 35162 00409D634A22 35162 00409D634A23 35162 00409D634A24 35162 00409D634A28 35162 00409D634A2F 35162 00409D634A31 35162 00409D634A33 35162 00409D634A36 35162 00409D634A37 35162 00409D634A3B 35162 00409D634A52 35162 00409D634A5B 35162 00409D634A5D 35162 00409D634A5F 35162 00409D634A64 35162 00409D634A65 35162 00409D634A6D 35162 00409D634A75 35162 00409D634A7B 35162 00409D634A7C 35162 00409D634A7D 35162 00409D634A7F 35162 00409D634A80 35162 00409D634A88 35162 00409D634A8B 35162 00409D634A8C 35162 00409D634A8E 35162 00409D634A92 35162 00409D634A95 35162 00409D634FA0 35162 00409D634FB6 35162 00409D635076 35162 00409D6350AE 35162 00409D6350AF 35162 00409D6350B0 35162 00409D6350B3 35162 00409D6350B4 35162 00409D6350BA 35162 00409D6350BB 35162 00409D6350BD 35162 00409D6350BE 35162 00409D6350C2 35162 00409D6350C3 35162 00409D6350C5 35162 00409D6350D7 35162 00409D6350DA 35162 00409D6350DE 35162 00409D6350E0 35162 00409D6350E1 35162 00409D6350E2 35162 00409D6350E4 35162 00409D6350E8 35162 00409D6350EC 35162 00409D6350F2 35162 00409D6350FA 35162 00409D6350FC 35162 00409D6352BF 35162 00409D635433 35162 00409D63F794 35162 00409D63F795 35162 00409D63F7AF 35162 00409D63F7C8 35162 00409D63F7CA 35162 00409D63F7CB 35162 00409D63F7D2 35162 00409D63F7D4 35162 00409D63F7D5 35162 00409D63F7DB 35162 00409D63F7DD 35162 00409D63F7DF 35162 00409D63F7FA 35162 00409D63F888 35162 00409D63F9E4 35162 00409D63FA51 35162 00409D63FA55 35162 00409D63FA56 35162 00409D63FA59 35162 00409D63FA5C 35162 00409D63FA5F 35162 00409D63FA61 35162 00409D63FA62 35162 00409D63FA64 35162 00409D63FA65 35162 00409D63FA66 35162 00409D63FA6A 35162 00409D63FA6B 35162 00409D63FA6C 35162 00409D63FA6D 35162 00409D63FA6E 35162 00409D63FA70 35162 00409D63FA71 35162 00409D63FA74 35162 00409D63FA75 35162 00409D63FA76 35162 00409D63FA77 35162 00409D63FA79 35162 00409D63FA7A 35162 00409D63FA7B 35162 00409D63FA7C 35162 00409D63FA7E 35162 00409D63FA83 35162 00409D63FA8A 35162 00409D63FA8C 35162 00409D63FA8E 35162 00409D63FA8F 35162 00409D63FA92 35162 00409D63FA97 35162 00409D63FA9B 35162 00409D63FBAF 35162 00409D63FBC3 35162 00409D63FBCD 35162 00409D63FBDB 35162 00409D63FE0E 35162 00409D80983D 35162 00409D80985E 35162 00409D816199 35162 00409D8221F9 35162 00409D8221FA 35162 00409D8221FC 35162 00409D8221FE 35162 00409D8221FF 35162 00409D822200 35162 00409D822201 35162 00409D822202 35162 00409D822203 35162 00409D822204 35162 00409D822205 35162 00409D822206 35162 00409D822208 35162 00409D822209 35162 00409D82220C 35162 00409D82220D 35162 00409D82220F 35162 00409D822210 35162 00409D822213 35162 00409D822216 35162 00409D822217 35162 00409D822218 35162 00409D822219 35162 00409D82221B 35162 00409D82221E 35162 00409D822220 35162 00409D822221 35162 00409D822222 35162 00409D822223 35162 00409D822224 35162 00409D822225 35162 00409D822226 35162 00409D822227 35162 00409D822228 35162 00409D822229 35162 00409D82222A 35162 00409D82222C 35162 00409D82222E 35162 00409D82222F 35162 00409D822231 35162 00409D822265 35162 00409D822

26C 35162 00409D82226E 35162 00409D82226F 35162 00409D822272 35162 00409D822276 35162 00409D822277 35162 00409D82227B 35162 00409D82227C 35162 00409D82227D 35162 00409D82227E 35162 00409D82227F 35162 00409D822280 35162 00409D822281 35162 00409D822282 35162 00409D822283 35162 00409D822284 35162 00409D822285 35162 00409D822286 35162 00409D8222A0 35162 00409D8222A1 35162 00409D8222A4 35162 00409D8222A7 35162 00409D8222A8 35162 00409D8222AB 35162 00409D8222AC 35162 00409D8222AD 35162 00409D8222AF 35162 00409D8222B0 35162 00409D8222B1 35162 00409D8222B2 35162 00409D8222B3 35162 00409D8222B4 35162 00409D8222B5 35162 00409D8222B6 35162 00409D8222B7 35162 00409D8222B8 35162 00409D8222B9 35162 00409D8222BB 35162 00409D8222C0 35162 00409D8222F2 35162 00409D8222F8 35162 00409D8222F9 35162 00409D82389E 35162 00409D8238A2 35162 00409D8238A3 35162 00409D8238A5 35162 00409D8238B0 35162 00409D8238DF 35162 00409D823C0E 35162 00409D823D2D 35162 00409D823D33 35162 00409D823D3A 35162 00409D823D3F 35162 00409D823D40 35162 00409D823D41 35162 00409D823D45 35162 00409D823D46 35162 00409D823D48 35162 00409D823D4A 35162 00409D823D4C 35162 00409D823D4E 35162 00409D823E90 35162 00409D823E92 35162 00409D823E94 35162 00409D823EA7 35162 00409D823EB1 35162 00409D823EB2 35162 00409D823EB5 35162 00409D823EB6 35162 00409D823EB8 35162 00409D823EBB 35162 00409D823EBC 35162 00409D823EBD 35162 00409D823EBE 35162 00409D823EBF 35162 00409D823EC5 35162 00409D823EC8 35162 00409D823EC9 35162 00409D824058

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SECRETARY OF THE STATE OF CONNECTICUT

5. ALTERNATIVE DESIGNATION (if applicable) :

- ☒ LESSEE/LESSOR
- ☐ CONSIGNEE/CONSIGNOR
- ☐ BAILEE/BAILOR
- ☐ SELLER/BUYER
- ☐ NONE

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6. DEBTOR IS (if applicable) :

- ☐ TRUST
- ☐ TRUSTEE ACTING WITH RESPECT TO PROPERTY HELD IN TRUST
- ☐ DESCENDANT'S ESTATE
- ☒ NONE

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7. Check only if applicable :

- ☐ Debtor is a TRANSMITTING UTILITY
- ☐ Filed in connection with Public Finance Transaction
- ☒ NONE

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8. OPTIONAL FILER REFERENCE DATA :

CT-0-49597500

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Phone: (800) 331-3282 Fax: (818) 662-4141

B. E-MAIL CONTACT AT FILER (optional)
CLS-CTLS_Glendale_Customer_Service@wolterskluwer.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address) 11914 - GE Capital

CT Lien Solutions
P.O. Box 29071
Glendale, CA 91209-9071

51979804

CTCT

File with: Secretary of State, CT

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FILED 01/11/2016 08:30 AM PAGE 01936
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME
THE WATERBURY HOSPITAL

OR

1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
PO BOX 10016	WATERBURY	CT	067250016	USA

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME
IKON FINANCIAL SVCS

OR

3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1738 BASS RD	MACON	GA	312101043	USA

4. COLLATERAL: This financing statement covers the following collateral:
The terms "Debtor" and "Secured Party" shall mean "Lessor" and "Lessee", respectively. This financing statement covers the following types (or items) of property: All equipment now or hereafter leased in an equipment leasing transaction in connection with that certain Master Agreement No. see below, Product Schedule No./Agreement No. see below ("Lease"), as amended from time to time, between IOS Capital, LLC as lessor, and the above referenced Lessee/Debtor, including, without limit, the equipment listed below, and all additions, improvements, attachments, accessories, accessions, upgrades and replacements related thereto, and any and all substitutions or exchanges, and any and all products, insurance and/or other proceeds (cash and non-cash) there from: The equipment location is as identified in the Lease. This is intended to be a true lease transaction. Neither the execution nor filing of this financing statement shall in any manner imply that the relationship between the parties to which this document applies is other than lessor and lessee, respectively. This financing statement is filed solely to protect the interests of the

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and Instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☒ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA:
51979804 1026936 1026936ML

FILING OFFICE COPY — UCC FINANCING STATEMENT (Form UCC1) (Rev. 04/20/11)

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

UCC FINANCING STATEMENT ADDENDUM

FOLLOW INSTRUCTIONS

9. NAME OF FIRST DEBTOR: Same as line 1a or 1b on Financing Statement; if line 1b was left blank because Individual Debtor name did not fit, check here ☐

9a. ORGANIZATION'S NAME
THE WATERBURY HOSPITAL

OR

9b. INDIVIDUAL'S SURNAME

FIRST PERSONAL NAME

ADDITIONAL NAME(S)/INITIAL(S) | SUFF

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FILED 01/11/2016 08:30 AM PAGE 01937
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

THE ABOVE SPACE...

10. DEBTOR'S NAME: Provide (10a or 10b) only one additional Debtor name or Debtor name that did not fit in line 1b or 2b of the Financing Statement (Form UCC1) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name) and enter the mailing address in line 10c

10a. ORGANIZATION'S NAME

OR

10b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

10c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

11. ☐ ADDITIONAL SECURED PARTY'S NAME or ☐ ASSIGNOR SECURED PARTY'S NAME: Provide only one name (11a or 11b)

11a. ORGANIZATION'S NAME

OR

11b. INDIVIDUAL'S SURNAME | FIRST PERSONAL NAME | ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

11c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

parties in the event of unwarranted assertions by any third party. This statement is filed in connection with a lease transaction and is filed for precautionary purposes only.

Product Schedule No./Agreement No. 1026936ML, Master Agreement/Lease No. 1026936. CUSTOMER: 103513 RISP4510DN C81074126 RISP4510DN C81074137 RISP4510DN C81075393 RISP4510DN C81074679 RISP4510DN C81074678 RISP4510DN C81074817 RISP4510DN C81074816 RISP4510DN C81074815 RISP4510DN C81074135 RISP4510DN C81074677 RISP4510DN C81073261 RISP4510DN C81074131 RISP4510DN C81075392 RISP4510DN C81074814 RISP4510DN C81074813 RISP4510DN C81074812 RISP4510DN C81074811 RISP4510DN C81074819 RISP4510DN C81074818 RISP4510DN C81074132 RISP4510DN C81074138 RISP4510DN C81074672 RISP4510DN C81076092 RISP4510DN C81074178 RISP4510DN C81074136 RISP4510DN C81074810 RISP4510DN C81073873 RISP4510DN C81073785 RISP4510DN

13. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS (if applicable)

14. This FINANCING STATEMENT:
☐ covers timber to be cut ☐ covers as-extracted collateral ☐ is filed as a fixture filing

15. Name and address of a RECORD OWNER of real estate described in item 16 (if Debtor does not have a record interest):

16. Description of real estate:

17. MISCELLANEOUS: 51979804-CT-0 11914 - GE Capital Informati IKON FINANCIAL SVCS File with: Secretary of State, CT 1026936 1026936ML

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

UCC FINANCING STATEMENT ADDENDUM

FOLLOW INSTRUCTIONS

9. NAME OF FIRST DEBTOR: Same as line 1a or 1b on Financing Statement; if line 1b was left blank because Individual Debtor name did not fit, check here ☐

9a. ORGANIZATION'S NAME
THE WATERBURY HOSPITAL

OR

9b. INDIVIDUAL'S SURNAME

FIRST PERSONAL NAME

ADDITIONAL NAME(S)/INITIAL(S)

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FILED 01/11/2016 08:30 AM PAGE 01938
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

10. DEBTOR'S NAME: Provide (10a or 10b) only one additional Debtor name or Debtor name that did not fit in line 1b or 2b of the Financing Statement (Form UCC1) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name) and enter the mailing address in line 10c

10a. ORGANIZATION'S NAME

OR

10b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

10c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

11. ☐ ADDITIONAL SECURED PARTY'S NAME or ☐ ASSIGNOR SECURED PARTY'S NAME: Provide only one name (11a or 11b)

11a. ORGANIZATION'S NAME

OR

11b. INDIVIDUAL'S SURNAME | FIRST PERSONAL NAME | ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

11c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

C81074675 RISP4510DN C81074674 RISP4510DN C81074130 RISP5210DNHT C81073159 RISP4510DN C81074129 RISP4510DN C81074128 RISP4510DN C81074127 RISP4510DN C81074809 RISP4510DN C81076082 RISP4510DN C81073260 RISP4510DN C81074673 RISP4510DN C81074125 RISP4510DN C81074124 RISP4510DN C81075384 RISP4510DN C81075408 RISP4510DN C81075391 RISP4510DN C81075390 RISP4510DN C81075389 RISP4510DN C81076086 RISP4510DN C81076091 RISP4510DN C81074676 RISP4510DN C81075385 RISP4510DN C81075383 RISP4510DN C81074121 RISPC320DN C81076226 RISPC320DN C81074088 RISPC320DN C81074802 RISPC320DN C81074087 RISPC320DN C81074089 RISP5210DNHT C81074073 RISP5210DNHT C81074072 RISP5210DNHT C81074665 RISP5210DNHT C81074664 RISP5210DNHT C81074663 RISP5210DNHT C81073752 RISP5210DNHT C81074668 RISP5210DNHT C81074667 RISP5210DNHT C81074071 RISP5210DNHT C81074799 RISP5210DNHT C81074797 RISP5210DNHT C81073253 RISP5210DNHT C81074796 RISP5210DNHT C81074666 RISP5210DNHT C81074074 RISP5210DNHT C81076224 RISP5210DNHT C81076223 RISP5210DNHT C81076222 RISP5210DNHT C81076239

13. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS (if applicable)

14. This FINANCING STATEMENT:
☐ covers timber to be cut ☐ covers as-extracted collateral ☐ is filed as a fixture filing

15. Name and address of a RECORD OWNER of real estate described in item 16 (if Debtor does not have a record interest):

16. Description of real estate:

17. MISCELLANEOUS: 51979804-CT-0 11914 - GE Capital Informati IKON FINANCIAL SVCS File with: Secretary of State, CT 1026936 1026936ML

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

UCC FINANCING STATEMENT ADDENDUM

FOLLOW INSTRUCTIONS

9. NAME OF FIRST DEBTOR: Same as line 1a or 1b on Financing Statement; if line 1b was left blank because Individual Debtor name did not fit, check here ☐

9a. ORGANIZATION'S NAME
THE WATERBURY HOSPITAL

OR

9b. INDIVIDUAL'S SURNAME

FIRST PERSONAL NAME

ADDITIONAL NAME(S)/INITIAL(S)

FILING #0003097903 PG 04 OF 05 VOL U-00576
FILED 01/11/2016 08:30 AM PAGE 01939
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

10. DEBTOR'S NAME: Provide (10a or 10b) only one additional Debtor name or Debtor name that did not fit in line 1b or 2b of the Financing Statement (Form UCC1) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name) and enter the mailing address in line 10c

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OR

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INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

10c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

11. ☐ ADDITIONAL SECURED PARTY'S NAME or ☐ ASSIGNOR SECURED PARTY'S NAME: Provide only one name (11a or 11b)

11a. ORGANIZATION'S NAME

OR

11b. INDIVIDUAL'S SURNAME | FIRST PERSONAL NAME | ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

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12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

RISP5210DNHT C81073779 RISP5210DNHT C81075365 RISP5210DNHT C81075382 RISP5210DNHT C81074795 RISP5210DNHT C81073751 RISP5210DNHT C81075364 RISP5210DNHT C81073778 RISP5210DNHT C81073750 RISP5210DNHT C81073755 RISP5210DNHT C81073749 RISP5210DNHT C81075367 RISP5210DNHT C81076070 RISP5210DNHT C81074801 RISP5210DNHT C81074800 RISP5210DNHT C81075363 RISP5210DNHT C81075362 RISP5210DNHT C81075366 RISP5210DNHT C81076217 RISP5210DNHT C81076221 RISP5210DNHT C81076216 RISP5210DNHT C81076215 RISP5210DNHT C81076214 RISP5210DNHT C81076074 RISP5210DNHT C81076073 RISP5210DNHT C81076238 RISP5210DNHT C81076237 RISPC320DN C81076225 RISP4510DN C81074823 RISP4510DN C81075395 RISP4510DN C81074680 RISP4510DN C81074134 RISP4510DN C81073792 RISP4510DN C81075394 RISP4510DN C81074821 RISP4510DN C81073791 RISP4510DN C81073790 RISP4510DN C81074820 RISP4510DN C81073789 RISP4510DN C81073788 RISP4510DN C81074133 RISP4510DN C81074123 RISP4510DN C81074681 RISP4510DN C81074825 RISP4510DN C81073793 RISP4510DN C81074122 RISP4510DN C81074824 RISP4510DN C81073262

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FILING OFFICE COPY — UCC FINANCING STATEMENT ADDENDUM (Form UCC1Ad) (Rev. 04/20/11)

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

UCC FINANCING STATEMENT ADDENDUM

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FIRST PERSONAL NAME

ADDITIONAL NAME(S)/INITIAL(S)

FILING #0003097903 PG 05 OF 05 VOL U-00576
FILED 01/11/2016 08:30 AM PAGE 01940
SECRETARY OF THE STATE
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RISP4510DN C81074822 RISP4510DN C81073787 RISP4510DN C81075388 RISP4510DN C81075387 RISP4510DN C81075386 RISP4510DN C81073786 RISP4510DN C81076258 RISP4510DN C81076257 RISP4510DN C81076245 RISP4510DN C81076244 RISP4510DN C81076243 RISP4510DN C81076084 RISP4510DN C81076083 RISP4510DN C81076081 RISP4510DN C81076080 RISP4510DN C81076108 RISP4510DN C81076242 RISP4510DN C81076256 RISP4510DN C81076255 RISP4510DN C81076246 RISP4510DN C81076090 RISP4510DN C81076089 RISP4510DN C81076088 RISP4510DN C81076087 RISP4510DN C81076106 RISP4510DN C81076085 RISP4510DN C81076241

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16. Description of real estate:

17. MISCELLANEOUS: 51979904-CT-0 11914 - GE Capital Informati IKON FINANCIAL SVCS File with: Secretary of State, CT 1026936 1026936ML

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

SECRETARY OF THE STATE OF CONNECTICUT
UCC-1 FINANCING STATEMENT

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VOL 00584 PAGE 2769
FILED ON 04/11/2016 04:14 PM
SECRETARY OF THE STATE OF CONNECTICUT

1. DEBTOR NAMES AND ADDRESSES:

BUSINESS NAME : WATERBURY HOSPITAL
ADDRESS1 : 64 ROBBINS ST.
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : WATERBURY , CT 16721
COUNTRY :

2. SECURED PARTY NAMES AND ADDRESSES:

BUSINESS NAME : TERUMO CARDIOVASCULAR SYSTEMS
ADDRESS1 : 6200 JACKSON ROAD
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : ANN ARBOR , MI 48103
COUNTRY :

3. ASSIGNOR NAMES AND ADDRESSES:

NONE

FILING #0003113081 PG 2 OF 3
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FILED ON 04/11/2016 04:14 PM
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4. This FINANCING STATEMENT covers the following collateral:

3005-001-110-CL (Qty 2) Spectrum M2 Monitor 3003-010-020-CK (Qty 2) Spectrum S02-HCT Sensor 3/8

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VOL 00584 PAGE 2771
FILED ON 04/11/2016 04:14 PM
SECRETARY OF THE STATE OF CONNECTICUT

5. ALTERNATIVE DESIGNATION (if applicable) :

- ☐ LESSEE/LESSOR
- ☐ CONSIGNEE/CONSIGNOR
- ☐ BAILEE/BAILOR
- ☐ SELLER/BUYER
- ☒ NONE

6. DEBTOR IS (if applicable) :

- ☐ TRUST
- ☐ TRUSTEE ACTING WITH RESPECT TO PROPERTY HELD IN TRUST
- ☐ DESCENDANT'S ESTATE
- ☒ NONE

7. Check only if applicable :

- ☐ Debtor is a TRANSMITTING UTILITY
- ☐ Filed in connection with Public Finance Transaction
- ☒ NONE

8. OPTIONAL FILER REFERENCE DATA :

:16891892

[redacted]

FILING #0003121843 PG 01 OF 05 VOL U-00590
FILED 05/23/2016 08:30 AM PAGE 00081
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Phone: (800) 331-3282 Fax: (818) 662-4141

B. E-MAIL CONTACT AT FILER (optional)
CLS-CTLS_Glendale_Customer_Service@wolterskluwer.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address) 11914 - GE Capital

CT Lien Solutions
P.O. Box 29071
Glendale, CA 91209-9071

54039287
CTCT

File with: Secretary of State, CT

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME
THE WATERBURY HOSPITAL

OR

1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
PO BOX 10016	WATERBURY	CT	067250016	USA

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME
IKON FINANCIAL SVCS

OR

3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1738 BASS RD	MACON	GA	312101043	USA

4. COLLATERAL: This financing statement covers the following collateral:
The terms "Debtor" and "Secured Party" shall mean "Lessor" and "Lessee", respectively. This financing statement covers the following types (or items) of property: All equipment now or hereafter leased in an equipment leasing transaction in connection with that certain Master Agreement No. see below, Product Schedule No./Agreement No. see below ("Lease"), as amended from time to time, between IOS Capital, LLC as lessor, and the above referenced Lessee/Debtor, including, without limit, the equipment listed below, and all additions, improvements, attachments, accessories, accessions, upgrades and replacements related thereto, and any and all substitutions or exchanges, and any and all products, insurance and/or other proceeds (cash and non-cash) there from: The equipment location is as identified in the Lease. This is intended to be a true lease transaction. Neither the execution nor filing of this financing statement shall in any manner imply that the relationship between the parties to which this document applies is other than lessor and lessee, respectively. This financing statement is filed solely to protect the interests of the

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and Instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☒ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA:
54039287 1026936 1026936A1

FILING OFFICE COPY — UCC FINANCING STATEMENT (Form UCC1) (Rev. 04/20/11)

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

FILING #0003121843 PG 02 OF 05 VOL U-00590
FILED 05/23/2016 08:30 AM PAGE 00082
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT ADDENDUM

FOLLOW INSTRUCTIONS

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THE WATERBURY HOSPITAL

OR

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FIRST PERSONAL NAME

ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

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INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

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11c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

parties in the event of unwarranted assertions by any third party. This statement is filed in connection with a lease transaction and is filed for precautionary purposes only.

Product Schedule No./Agreement No. 1026936A1, Master Agreement/Lease No. 1026936. CUSTOMER: 103513 RIMP301SPF C81074828 RIMP301SPF C81074804 RIMP301SPF C81074829 RIMP5054SP C81074807 RIMPC3003 C81075398 RIMPC3003 C81075396 RIMPC3003 C81075397 RISP5200SHT S9049400318 RISP5200SHT S9039600900 RISP5200SHT S9058500312 RISP5200SHT S9058500201 RISP5200SHT S9058500334 RISP5200SHT S9058500110 RISP5200SHT S9058500155 RISP5200SHT S9059100196 RIMPC305SPF C81074159 RIMPC305SPF C81073845 RIMP7502SP C81076250 RIMPC401SR C81075411 RIMPC401SR C81075369 RIMP301SPF C81075375 RIMP301SPF C81074827 RIMP301SPF C81074805 RIMP301SPF C81074806 RIMP301SPF C81076230 RIMP301SPF C81076227 RIMP301SPF C81076261 RISP5200SHT

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16. Description of real estate:

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Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

FILING #0003121843 PG 03 OF 05 VOL U-00590
FILED 05/23/2016 08:30 AM PAGE 00083
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT ADDENDUM

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12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

S9059100182 RISP5200SHT S9058500089 RISP5200SHT S9059100137 RISP5200SHT S9048700011 RISP5200SHT S9059100200 RISP5200SHT S9059100192 RISP5200SHT S9059100183 RISP5200SHT S9059100198 RISP5200SHT S9059100195 RISP5200SHT S9058500120 RISP5200SHT S9048800484 RIMPC5503 C81074808 RISP5200SHT S9039601053 RISP5200SHT S9048800335 SAMP4054SP C81076249 RIMP301SPF C81076228 RIMP301SPF C81076260 RIMP301SPF C81076259 RIMP301SPF C81076078 RISP5210SR C81076247 RISP5210SR C81076253 RISP5210SR C81076252 RISP5210SR C81076107 RISP5210SR C81075407 RISP5210SR C81075406 RISP5210SR C81075404 RISP5210SR C81075405 RIMP301SPF C81076079 RIMP301SPF C81074170 RIMP301SPF C81074111 RIMP301SPF C81074169 RIMP301SPF C81074168 RIMP301SPF C81073768 RIMP301SPF C81073863 RIMP301SPF C81073869 RISP5210SR C81075403 RISP5210SR C81074798 RISP5210SR C81074685 RIMPC5503 C81076077 RISP5210SR C81074684 RIMP301SPF C81073864 RIMP301SPF C81073770 RIMP301SPF C81073867 RIMPC305SPF C81074158 RIMPC401SR C81076076 RIMPC3503 C81074803 RISP5210SR C81073841 RIMP6002SP C81076240 RISP5210SR

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C81073840 RISP5210SR C81073842 RISP5210SR C81073757 RISP5210SR C81073756 RISP5210SR C81073758 RISP5210SR C81073158 RISP5210SR C81074662 RIMPC6003 C81074683 RIMP6002SP C81074670 RIMP5054SP C81074110 RIMP5054SP C81076300 RIMP5054SP C81076324 RISP5210SR C81075371 RISP5210SR C81075372 RISP5210SR C81076071 RIMPC3503 C81074669 RIMPC4503 C81074119 RIMPC305SPF C81073759 RIMP5054SP C81075401 RIMPC305SPF C81076109 RIMPC4503 C81074142 RIMPC4503 C81074140 RIMPC4503 C81074141 RIMPC4503 C81076248 RIMP5054SP C81075400 SAMP4054SP C81074830 SAMP4054SP C81076251 RIMPC4503 C81074165 RIMPC4503 C81074118 RIMPC4503 C81076069 RIMPC401SR C81076218 RISP5200SHT S9058500310 RIMPC4503 C81074826 RIMP301SPF C81073866 RIMP301SPF C81073865 RIMP301SPF C81073769 RIMPC3003 C81074682 RIMP301SPF C81073160 RIMP301SPF C81076234 RIMP301SPF C81076236 RIMP301SPF C81076233 RIMPC4503 C81073807 RIMPC4503 C81073808 RIMP6002SP C81073777 RIMP5054SP C81075402 RIMP5054SP C81075399 RIMP5054SP C81073838 SAMP4054SP C81076254 RIMP301SPF C81076235 RIMP301SPF C81076110

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Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

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FILED 05/23/2016 08:30 AM PAGE 00085
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

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11c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

RIMP301SPF C81075377 RIMP301SPF C81076229 RIMP301SPF C81076008 RIMP301SPF C81076231 RIMP301SPF C81076232 RIMP301SPF C81075378 RIMP301SPF C81075373 SAMP4054SP C81074172 SAMP4054SP C81074173 SAMP4054SP C81075410 SAMP4054SP C81075409 SAMP4054SP C81073858 RIMP6002SP C81075381 RIMP301SPF C81075380 RIMP301SPF C81075376 RIMP301SPF C81075374 RIMP301SPF C81075379 RIMP301SPF C81074671 RIMP301SPF C81074114 RIMP301SPF C81074113 RIMP301SPF C81074115 RIMP301SPF C81074167 RIMP301SPF C81074112 RIMP301SPF C81073772 RIMP301SPF C81073868 RIMP301SPF C81073771 SAMP4054SP C81073857 SAMP4054SP C81076262 RISP5200SHT S9058500307 RISP5200SHT S9048800221 RISP5200SHT S9058500121 RISP5200SHT S9048800485 RISP5200SHT S9058500136 RISP5200SHT S9048700044 RISP5200SHT S9058500337 RIMPC305SPF C81074686 RIMPC305SPF C81073760 RIMPC401SR C81075370 RIMPC401SR C81076220 RIMPC401SR C81076219 RIMPC401SR C81074086 RIMPC401SR C81075368

13. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS (if applicable)

14. This FINANCING STATEMENT:
☐ covers timber to be cut ☐ covers as-extracted collateral ☐ is filed as a fixture filing

15. Name and address of a RECORD OWNER of real estate described in item 16 (if Debtor does not have a record interest):

16. Description of real estate:

17. MISCELLANEOUS: 54039287-CT-0 11914 - GE Capital Informati IKON FINANCIAL SVCS File with: Secretary of State, CT 1026936 1026936A1

Prepared by CT Lien Solutions, P.O. Box 29071, Glendale, CA 91209-9071 Tel (800) 331-3282

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR: Marisol Skibicki at 561
REF. NO: 3274-1135
DATE: 06/30/16
INDEX DATE: 06/17/16
IRS INDEX DATE: 06/23/16
DRC REF. NO: 506518

REGARDING: GREATER WATERBURY HEALTH NETWORK

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There are 5 presently effective records under the debtor name.

[**X**] See attached

1) 2791046
2) 3087055
3) 3087102
4) 3094138
5) 3043716

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michael P. Botelho, Esq.
Updike, Kelly & Spellacy, P.C.
One State Street
Hartford, CT 06103

FILING #0002791046 PG 01 OF 02 VOL U-00430
FILED 12/22/2010 12:00 PM PAGE 02183
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S EXACT FULL LEGAL NAME – insert only one debtor name (1a or 1b) – do not abbreviate or combine names

1a. ORGANIZATION'S NAME: Greater Waterbury Health Network, Inc.

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
64 Robbins Street	Waterbury	CT	06708	USA

1d. TAX ID #: SSN OR EIN	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		Corporation	Connecticut	☒ None

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME – insert only one debtor name (2a or 2b) – do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. TAX ID #: SSN OR EIN	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ None

3. SECURED PARTY'S NAME (or NAME of TOTAL ASSIGNEE of ASSIGNOR S/P) – insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: RBS Citizens, National Association

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
63 Eugene O'Neill Drive	Hartford	CT	06103	USA

4. This FINANCING STATEMENT covers the following collateral:

The Debtor hereby grants to the Secured Party a security interest in the collateral described in Schedule A, attached hereto and made a part hereof.

5. ALTERNATIVE DESIGNATION [if applicable]: ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA

581356 CT SOS (Bond Loan)

FILING OFFICE COPY – NATIONAL UCC FINANCING STATEMENT (FORM UCC1) (REV. 07/29/98)

581356

FILING #0002791046 PG 02 OF 02 VOL U-00430
FILED 12/22/2010 12:00 PM PAGE 02184
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

SCHEDULE A TO

UCC FINANCING STATEMENT

(Secretary of the State – Gross Receipts)

Debtor: **GREATER WATERBURY HEALTH NETWORK, INC.**
64 Robbins Street
Waterbury, CT 06708

Secured Party: RBS Citizens, National Association
63 Eugene O'Neill Drive
Hartford, CT 06103

Collateral: This financing statement covers the following properties, assets and rights of Debtor, wherever located, whether now owned or hereafter acquired or arising and all proceeds and products thereof:

(a) all Gross Receipts (as hereinafter defined) including, without limiting the generality of the foregoing, all rights to receive Gross Receipts whether in the form of accounts, accounts receivable, contract rights or other rights and to the proceeds of such rights; and

(b) all of Debtor's rights in and to all funds and all accounts established in and more particularly described, as the case may be, in that certain Loan Agreement (and Security Agreement) between the State of Connecticut Health and Educational Facilities Authority (**"CHEFA"**), Debtor and Secured Party dated as of December 1, 2010 ("Loan Agreement'), relating to the issuance of CHEFA's Revenue Bonds, Waterbury Hospital Issue, Series D (the **"Bonds"**).

For purposes hereof **"Gross Receipts"** means all receipts, revenues, income and other moneys received by or on behalf of the Debtor, including, but without limiting the generality of the foregoing, revenues derived from the ownership or operation of the properties and assets of the Debtor, including insurance and condemnation proceeds with respect to such properties and assets, or any portion thereof; and all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights, and the proceeds of such rights and whether now owned or held or hereafter coming into existence; **provided, however** that Gross Receipts shall not include (i) gifts, grants, bequests, donations and contributions heretofore or hereafter made and designated or specified by the granting authority, donor or maker thereof as being for specified purposes (other than payment of debt service on the Indebtedness (as that term is defined in the Loan Agreement) of the Debtor) and the income derived therefrom to the extent required by such designation or specification, and (ii) cash, cash equivalents, investment securities, endowment funds from time to time on hand with the Debtor, except to the extent derived from Gross Receipts after an Event of Default (as defined in the Loan Agreement).

[redacted]

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Michelle Walters Fournier (860.240.2935)

B. E-MAIL CONTACT AT FILER (optional)
michelle.fournier@morganlewis.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michelle Walters Fournier
Senior Paralegal
Morgan, Lewis & Bockius LLP
One State Street
Hartford, CT 06103

FILING #0003087055 PG 01 OF 01 VOL U-00570
FILED 11/05/2015 08:30 AM PAGE 01054
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1a. INITIAL FINANCING STATEMENT FILE NUMBER
0002791046

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS
Filer: attach Amendment Addendum (Form UCC3Ad) and provide Debtor's name in item 13

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to the security interest(s) of Secured Party authorizing this Termination Statement

3. ☐ ASSIGNMENT (full or partial): Provide name of Assignee in item 7a or 7b, and address of Assignee in item 7c and name of Assignor in item 9
For partial assignment, complete items 7 and 9 and also indicate affected collateral in item 8

4. ☐ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to the security interest(s) of Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law

5. ☑ PARTY INFORMATION CHANGE:

Check one of these two boxes: AND Check one of these three boxes to:

This Change affects ☐ Debtor or ☑ Secured Party of record ☑ CHANGE name and/or address: Complete item 6a or 6b; and item 7a or 7b and item 7c ☐ ADD name: Complete item 7a or 7b, and item 7c ☐ DELETE name: Give record name to be deleted in item 6a or 6b

6. CURRENT RECORD INFORMATION: Complete for Party Information Change - provide only one name (6a or 6b)

6a. ORGANIZATION'S NAME
RBS Citizens, National Association

OR

6b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

7. CHANGED OR ADDED INFORMATION: Complete for Assignment or Party Information Change - provide only one name (7a or 7b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name)

7a. ORGANIZATION'S NAME
Citizens Bank, National Association

OR

7b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
100 Sockanosset Cross Road, RDC395B	**Cranston**	**RI**	**02920**	**US**

8. ☐ COLLATERAL CHANGE: Also check one of these four boxes: ☐ ADD collateral ☐ DELETE collateral ☐ RESTATE covered collateral ☐ ASSIGN collateral

Indicate collateral:

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT: Provide only one name (9a or 9b) (name of Assignor, if this is an Assignment)
If this is an Amendment authorized by a DEBTOR, check here ☐ and provide name of authorizing Debtor

9a. ORGANIZATION'S NAME
CITIZENS BANK, NATIONAL ASSOCIATION (formerly known as RBS Citizens, National Association)

OR

9b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

10. OPTIONAL FILER REFERENCE DATA:
To be filed with the Secretary of the State of the State of Connecticut

FILING #0003087102 PG 01 OF 01 VOL U-00570
FILED 11/06/2015 08:30 AM PAGE 01157
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

[redacted]

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Michelle Walters Fournier (860.240.2935)

B. E-MAIL CONTACT AT FILER (optional)
michelle.fournier@morganlewis.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michelle Walters Fournier
Senior Paralegal
Morgan, Lewis & Bockius LLP
One State Street
Hartford, CT 06103

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE NUMBER
0002791046

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS
Filer: attach Amendment Addendum (Form UCC3Ad) and provide Debtor's name in item 13

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to the security interest(s) of Secured Party authorizing this Termination Statement

3. ☐ ASSIGNMENT (full or partial): Provide name of Assignee in item 7a or 7b, and address of Assignee in item 7c and name of Assignor in item 9
For partial assignment, complete items 7 and 9 and also indicate affected collateral in item 8

4. ☑ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to the security interest(s) of Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law

5. ☐ PARTY INFORMATION CHANGE:

Check one of these two boxes: AND Check one of these three boxes to:

This Change affects ☐ Debtor or ☐ Secured Party of record ☐ CHANGE name and/or address: Complete item 6a or 6b; and item 7a or 7b and item 7c ☐ ADD name: Complete item 7a or 7b, and item 7c ☐ DELETE name: Give record name to be deleted in item 6a or 6b

6. CURRENT RECORD INFORMATION: Complete for Party Information Change - provide only one name (6a or 6b)

6a. ORGANIZATION'S NAME
Greater Waterbury Health Network, Inc.

OR

6b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

7. CHANGED OR ADDED INFORMATION: Complete for Assignment or Party Information Change - provide only one name (7a or 7b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name)

7a. ORGANIZATION'S NAME

OR

7b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

8. ☐ COLLATERAL CHANGE: Also check one of these four boxes: ☐ ADD collateral ☐ DELETE collateral ☐ RESTATE covered collateral ☐ ASSIGN collateral

Indicate collateral:

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT: Provide only one name (9a or 9b) (name of Assignor, if this is an Assignment)
If this is an Amendment authorized by a DEBTOR, check here ☐ and provide name of authorizing Debtor

9a. ORGANIZATION'S NAME
CITIZENS BANK, NATIONAL ASSOCIATION

OR

9b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

10. OPTIONAL FILER REFERENCE DATA:
To be filed with the Secretary of the State of the State of Connecticut

FILING OFFICE COPY — UCC FINANCING STATEMENT AMENDMENT (Form UCC3) (Rev. 04/20/11) International Association of Commercial Administrators (IACA)
DB1/85132612.1

[redacted]

FILING #0003094138 PG 01 OF 02 VOL U-00574
FILED 12/15/2015 08:30 AM PAGE 01246
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT AMENDMEI

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Michelle Walters Fournier (860.240.2935)

B. E-MAIL CONTACT AT FILER (optional)
michelle.fournier@morganlewis.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

Michelle Walters Fournier
Senior Paralegal
Morgan, Lewis & Bockius LLP
One State Street
Hartford, CT 06103

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE NUMBER
0002791046

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS
Filer: attach Amendment Addendum (Form UCC3Ad) and provide Debtor's name in item 13

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to the security interest(s) of Secured Party authorizing this Termination Statement

3. ☐ ASSIGNMENT (full or partial): Provide name of Assignee in item 7a or 7b, and address of Assignee in item 7c and name of Assignor in item 9
For partial assignment, complete items 7 and 9 and also indicate affected collateral in item 8

4. ☐ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to the security interest(s) of Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law

5. ☐ PARTY INFORMATION CHANGE:
Check one of these two boxes: AND Check one of these three boxes to:
This Change affects ☐ Debtor or ☐ Secured Party of record ☐ CHANGE name and/or address: Complete item 6a or 6b; and item 7a or 7b and item 7c ☐ ADD name: Complete item 7a or 7b, and item 7c ☐ DELETE name: Give record name to be deleted in item 6a or 6b

6. CURRENT RECORD INFORMATION: Complete for Party Information Change - provide only one name (6a or 6b)

6a. ORGANIZATION'S NAME
Greater Waterbury Health Network, Inc.

OR

6b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

7. CHANGED OR ADDED INFORMATION: Complete for Assignment or Party Information Change - provide only one name (7a or 7b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name)

7a. ORGANIZATION'S NAME

OR

7b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

8. ☑ COLLATERAL CHANGE: Also check one of these four boxes: ☐ ADD collateral ☐ DELETE collateral ☑ RESTATE covered collateral ☐ ASSIGN collateral
Indicate collateral:

See Schedule A attached hereto and incorporated herein.

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT: Provide only one name (9a or 9b) (name of Assignor, if this is an Assignment)
If this is an Amendment authorized by a DEBTOR, check here ☐ and provide name of authorizing Debtor

9a. ORGANIZATION'S NAME
CITIZENS BANK, NATIONAL ASSOCIATION

OR

9b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

10. OPTIONAL FILER REFERENCE DATA:
To be filed with the Secretary of the State of the State of Connecticut **Additional Pages - 1**

SCHEDULE A TO

UCC AMENDMENT

Debtor: GREATER WATERBURY HEALTH NETWORK, INC.
64 Robbins Street
Waterbury, CT 06708

Secured Party: CITIZENS BANK, NATIONAL ASSOCIATION
100 Sockanosset Cross Road
RDC395B
Cranston, RI 02920

Collateral: This financing statement covers the following properties, assets and rights of Debtor, wherever located, whether now owned or hereafter acquired or arising and all proceeds and products thereof:

(a) all Gross Receipts (as hereinafter defined) including, without limiting the generality of the foregoing, all rights to receive Gross Receipts whether in the form of accounts, accounts receivable, contract rights or other rights and to the proceeds of such rights; and

(b) all of Debtor's rights in and to all funds and all accounts established in and more particularly described, as the case may be, in that certain Loan Agreement (and Security Agreement) between the State of Connecticut Health and Educational Facilities Authority ("**CHEFA**"), Debtor and Secured Party dated as of December 1, 2010, as amended by that certain Forbearance and Modification Agreement between Debtor and Secured Party dated December 7, 2015 (collectively, the "**Loan Agreement**"), relating to the issuance of CHEFA's Revenue Bonds, Waterbury Hospital Issue, Series D.

For purposes hereof "**Gross Receipts**" means all receipts, revenues, income, cash, cash equivalents and investment securities and other moneys received by or on behalf of the Debtor, including, but without limiting the generality of the foregoing, contributions, donations and pledges, whether in the form of cash, securities, or other personal property, revenues derived from the ownership or operation of the properties and assets of the Debtor, including insurance and condemnation proceeds with respect to such properties and assets or any portion thereof, and all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights, and the proceeds of such rights, and whether now owned or held or hereafter coming into existence; provided, however, that Gross Receipts shall not include gifts, grants, bequests, donations and contributions heretofore or hereafter made and designated or specified by the granting authority, donor or maker thereof as being for specified purposes (other than payment of debt service on the Indebtedness (as that term is defined in the Loan Agreement) of the Debtor) and the income derived therefrom to the extent required by such designation or specification or endowment funds or any other funds to the extent the granting of a security interest is prohibited by the terms of any agreement.

FILING #0003094138 PG 02 OF 02 VOL U-00574
FILED 12/15/2015 08:30 AM PAGE 01247
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

SECRETARY OF THE STATE OF CONNECTICUT
UCC-1 FINANCING STATEMENT

FILING **#0003043716** PG 1 OF 3
VOL **00546** PAGE **1216**
FILED ON **03/13/2015 04:27 PM**
SECRETARY OF THE STATE OF CONNECTICUT

1. DEBTOR NAMES AND ADDRESSES:

BUSINESS NAME : GREATER WATERBURY HEALTH NETWORK, INC.
ADDRESS1 : 64 ROBBINS ST
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : WATERBURY , CT 06708
COUNTRY :

2. SECURED PARTY NAMES AND ADDRESSES:

BUSINESS NAME : STRYKER FINANCE, A DIVISION OF STRYKER SALES CORPORATION
ADDRESS1 : 1111 OLD EAGLE SCHOOL ROAD
ADDRESS2 :
ADDRESS3 :
CITY/STATE/ZIP : WAYNE , PA 19087
COUNTRY :

3. ASSIGNOR NAMES AND ADDRESSES:

NONE

FILING #0003043716 PG 2 OF 3
VOL 00546 PAGE 1217
FILED ON 03/13/2015 04:27 PM
SECRETARY OF THE STATE OF CONNECTICUT

4. This FINANCING STATEMENT covers the following collateral:

One (1) Toshiba Aquilion Prime Fast Whole Body CT Scanner w/AIRD 3D INCLUDING ALL COMPONENTS, ADDITIONS, UPGRADES, ATTACHMENTS, ACCESSIONS, SUBSTITUTIONS, REPLACEMENTS AND PROCEEDS OF SUCH COLLATERAL. THIS FILING IS FOR PRECAUTIONARY PURPOSES IN CONNECTION WITH AN EQUIPMENT LEASING TRANSACTION AND IS NOT TO BE CONSTRUED AS INDICATING THAT THE TRANSACTION IS OTHER THAN A TRUE LEASE.

FILING #0003043716 PG 3 OF 3
VOL 00546 PAGE 1218
FILED ON 03/13/2015 04:27 PM
SECRETARY OF THE STATE OF CONNECTICUT

5. ALTERNATIVE DESIGNATION (if applicable) :

- ☐ LESSEE/LESSOR
- ☐ CONSIGNEE/CONSIGNOR
- ☐ BAILEE/BAILOR
- ☐ SELLER/BUYER
- ☒ NONE

---

6. DEBTOR IS (if applicable) :

- ☐ TRUST
- ☐ TRUSTEE ACTING WITH RESPECT TO PROPERTY HELD IN TRUST
- ☐ DESCENDANT'S ESTATE
- ☒ NONE

---

7. Check only if applicable :

- ☐ Debtor is a TRANSMITTING UTILITY
- ☐ Filed in connection with Public Finance Transaction
- ☒ NONE

---

8. OPTIONAL FILER REFERENCE DATA :

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR: Marisol Skibicki at 561
REF. NO: 3274-1135
DATE: 06/30/16
INDEX DATE: 06/17/16
IRS INDEX DATE: 06/23/16
DRC REF. NO: 506518

REGARDING: WATERBURY HOSPITAL HEALTH CENTER

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There is 1 presently effective record under the debtor name.

[**X**] See attached
1) 3063468

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Corporation Service Company 1-800-858-5294

B. E-MAIL CONTACT AT FILER (optional)
SPRFiling@cscinfo.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

101263126 - 359880
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecticut
(S.O.S.)

FILING #0003063468 PG 01 OF 04 VOL U-00557
FILED 06/24/2015 08:30 AM PAGE 00735
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME: Waterbury Hospital Health Center					
OR 1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)		SUFFIX	
1c. MAILING ADDRESS: PO Box 10016	CITY: Waterbury	STATE: CT	POSTAL CODE: 06725-0016	COUNTRY: USA	

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME				
OR 2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)		SUFFIX
2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME: Draeger Medical, Inc.				
OR 3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)		SUFFIX
3c. MAILING ADDRESS: 3135 Quarry Road	CITY: Telford	STATE: PA	POSTAL CODE: 18969	COUNTRY: USA

4. COLLATERAL: This financing statement covers the following collateral:

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and Instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☐ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA:
101263126

FILING OFFICE COPY — UCC FINANCING STATEMENT (Form UCC1) (Rev. 04/20/11)

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

FILING #000306346B PG 02 OF 04 VOL U-00557
FILED 06/24/2015 08:30 AM PAGE 00736
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Dräger

Confirmation Order

Customer no.
91047213

Our order	Date
219917730	06/09/2015

Please reference on inquiries

Customer
WATERBURY HOSP HEALTH CTR
ATTN: FRANK VENSEL
DIRECTOR OF CLINICAL ENGINEERING
64 ROBBINS ST
WATERBURY CT 06708-2613

Payer 91046333
WATERBURY HOSP HEALTH CTR
ATTN: FRANK VENSEL
DIRECTOR OF CLINICAL ENGINEERIN
PO BOX 10016
WATERBURY CT 06725-0016

Your order dated
05/12/2015
363548B

Ship to 91047213
WATERBURY HOSP HEALTH CTR
ATTN: FRANK VENSEL
DIRECTOR OF CLINICAL ENGINEERIN
64 ROBBINS ST
WATERBURY CT 06708-2613

Your contact person

SUSY MCLAUGHLIN
Tel.: 215-660-2464
Fax : 215-721-5811

Page 1 / 3 Full delivery / Direct Delivery

Line	Quant.	Part no.	Description	Unit price USD	Total price USD
			National account: Novation NCT T1		
			Shipping Charges per above National Account Confirmation no. to customer: Date confirmation to customer: Order-No. from customer: Date order from customer:		
			STANDARD DEL DATE		
			CONTACT INFO LISA 203-573-7335		
0010	1 EA	2M22380	**L Babytherm 8010 System**		
			****Specif.national properties**** Target country USA 120 V		

Draeger Medical, Inc.
Our Tax ID: 23-1699096
3135 Quarry Road; Telford, PA 18969
An Equal Opportunity Employer M / F / V / H
Telephone 800-437-2437
http://www.draeger.com

FILING #0000306346 8 PG 03 OF 04 VOL U-00557
FILED 06/24/2015 08:30 AM PAGE 00737
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Dräger

Confirmation Order

Customer no.
91047213

Our order: 219917730 | Date: 06/09/2015
Please reference on inquiries

Payer
91046333

Line	Quant.	Part no.	Description	Unit price USD	Total price USD
			*** **Basic unit** ***		
	1 EA	OPC6507	Babytherm 8010 Side walls white 15 CM	11,335.20	11,335.20
			See accessories		
	1 EA	OPC6501	Trolley, flexible height US Fairfield rail	2,068.80	2,068.80
	1 EA	OPC0372	With integrated Phototherapy	1,975.20	1,975.20
			With set hooked rail		
	1 EA	OPC0365	With swivel cupboard, right	709.60	709.60
			Value Babytherm 8010 System		**16,088.80**
0020	**1 EA**	**MX11000**	**L ThermoTrace Core (5pcs)**	51.00	51.00
0030	**1 EA**	**MX11001**	**L ThermoTrace_Peripheral_5pcs**	62.39	62.39
0040	**1 EA**	**MX11002**	**L ThermoPad (50St)**	38.17	38.17
			Net value excl. Sales Tax		**16,240.36**
			Final amount		**16,240.36**

The sale of the products identified herein is expressly subject to the Draeger Medical, Inc. - Terms and Conditions of Sale which are attached hereto and which may also be found at: http://www.draeger.com/termsandconditions.

Customer is hereby informed that section 1128B(b) of the Social Security Act requires that discounts and other reductions in price or the existence of discount programs be properly disclosed and reflected in the costs claimed or charges made by a provider under Medicare or a Federal or State Health Program.

PLEASE CHECK THIS ORDER CAREFULLY FOR ACCURACY IN PRICING, PART # AND

FILING #000306346B PG 04 OF 04 VOL U-00557
FILED 06/24/2015 08:30 AM PAGE 00738
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Dräger

Confirmation Order

Customer no.
91047213

Our order	Date
219917730	06/09/2015

Please reference on inquiries

Payer
91046333

Line	Quant.	Part no. Description	Unit price USD	Total price USD
		DESCRIPTION. Contact Customer Service immediately if there are any discrepancies. This acknowledgement and note constitutes the entire agreement with respect to the contemplated transaction and supersedes all previous negotiations, proposals, writings, advertisements, or publications. **Terms of delivery:** On day w/o unpacking **Arrival date** 06/22/2015 **Payment terms:** 30 days after invoice date Remit to: Draeger Medical Inc. PO Box 536432 Pittsburgh, PA 15253-5906 L = Positions delivered/dispatched		

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR:	Marisol Skibicki at 561
REF. NO:	3274-1135
DATE:	06/30/16
INDEX DATE:	06/17/16
IRS INDEX DATE:	06/23/16
DRC REF. NO:	506518

REGARDING: WATERBURY GASTROENTEROLOGY
CO-MANAGEMENT COMPANY, LLC

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There are no presently effective records under the debtor name.

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR: Marisol Skibicki at 561
REF. NO: 3274-1135
DATE: 06/30/16
INDEX DATE: 06/17/16
IRS INDEX DATE: 06/23/16
DRC REF. NO: 506519

REGARDING: ALLIANCE MEDICAL GROUP, INC.

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There are 7 presently effective records under the debtor name.

[**X**] See attached

1) 2608645
2) 2655720
3) 2768312
4) 2906100
5) 2893406
6) 2961680
7) 2962368

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

[redacted]

FILING #0002608645 PG 01 OF 01 VOL U-00372
FILED 12/14/2007 08:30 AM PAGE 03265
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]
CSC Diligenz, Inc. 1-800-858-5294

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

30909477
CSC Diligenz, Inc.
6500 Harbour Heights Pkwy, Suite 400
Mukilteo, WA 98275

Filed In: Connecticut (S.O.S.)

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (1a or 1b) - do not abbreviate or combine names

1a. ORGANIZATION'S NAME
Greater Waterbury Management Resources, Inc.

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1625 Straits Turnpike	Middlebury	CT	06762	USA

1d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		Inc.	CT	0161215 ☐ NONE

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name (2a or 2b) - do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ NONE

3. SECURED PARTY'S NAME (or NAME of TOTAL ASSIGNEE of ASSIGNOR S/P) - insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME
Mazuma Capital Corp

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
12257 Business Park Drive, Suite 225	Draper	UT	84020	USA

4. This FINANCING STATEMENT covers the following collateral:
Computer Hardware & Software along with all other Property leased under Lease Schedule No. 74-01 to Master Lease Agreement No. MCC1029 between Greater Waterbury Management Resources, Inc., as Lessee and Mazuma Capital Corp, as Lessor.

THIS IS A "TRUE LEASE". FILING IS FOR INFORMATIONAL PURPOSES ONLY. THE PARTIES DO NOT BELIEVE THE LEASE IS SUBJECT TO UCC9. THE PROPERTY IS OWNED BY LESSOR AND LEASED TO LESSEE. LESSEE DOES NOT HAVE THE RIGHT TO SELL OR PLEDGE THE PROPERTY.

5. ALTERNATIVE DESIGNATION [if applicable]: ☑ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA
CTSOS-121207-TD

30909477

FILING OFFICE COPY — UCC FINANCING STATEMENT (FORM UCC1) (REV. 05/22/02)

[redacted]

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]
CSC Diligenz, Inc. 1-800-858-5294

B. SEND ACKNOWLEDGMENT TO: (Name and Address)
36990110
CSC Diligenz, Inc.
6500 Harbour Heights Pkwy, Suite 400
Mukilteo, WA 98275

Filed In: Connecticut (S.O.S.)

FILING #0002655720 PG 01 OF 01 VOL U-00389
FILED 09/18/2008 08:30 AM PAGE 02136
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE #
0002608645 12/14/2007

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS.

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to security interest(s) of the Secured Party authorizing this Termination Statement.

3. ☐ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to security interest(s) of the Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law.

4. ☑ ASSIGNMENT (full or partial): Give name of assignee in item 7a or 7b and address of assignee in item 7c; and also give name of assignor in item 9.

5. AMENDMENT (PARTY INFORMATION): This Amendment affects ☐ Debtor or ☐ Secured Party of record. Check only one of these two boxes.

Also check one of the following three boxes and provide appropriate information in items 6 and/or 7.

☐ CHANGE name and/or address: Please refer to the detailed instructions in regards to changing the name/address of a party.

☐ DELETE name: Give record name to be deleted in item 6a or 6b.

☐ ADD name: Complete item 7a or 7b, and also item 7c; also complete items 7e-7g (if applicable).

6. CURRENT RECORD INFORMATION:

6a. ORGANIZATION'S NAME
Greater Waterbury Management Resources, Inc.

OR

6b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7. CHANGED (NEW) OR ADDED INFORMATION:

7a. ORGANIZATION'S NAME
TCF Equipment Finance, Inc.

OR

7b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
11100 Wayzata Blvd, Ste 801	Minnentonka	MN	55305	USA

7d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	7e. TYPE OF ORGANIZATION	7f. JURISDICTION OF ORGANIZATION	7g. ORGANIZATIONAL ID #, if any
				☐ NONE

8. AMENDMENT (COLLATERAL CHANGE): check only one box.

Describe collateral ☐ deleted or ☐ added, or give entire ☐ restated collateral description, or describe collateral ☐ assigned.

Full Assignment

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT (name of assignor, if this is an Assignment). If this is an Amendment authorized by a Debtor which adds collateral or adds the authorizing Debtor, or if this is a Termination authorized by a Debtor, check here ☐ and enter name of DEBTOR authorizing this Amendment.

9a. ORGANIZATION'S NAME
Mazuma Capital Corp

OR

9b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

10. OPTIONAL FILER REFERENCE DATA
CTSOS-121207-TD

36990110

FILING OFFICE COPY — UCC FINANCING STATEMENT AMENDMENT (FORM UCC3) (REV. 05/22/02)

[redacted]

FILING #0002768312 PG 01 OF 01 VOL U-00423
FILED 08/16/2010 08:30 AM PAGE 00844
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]
Corporation Service Company 1-800-858-5294

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

50822802 - 346290

Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703-4261

Filed In: Connecticut (S.O.S.)

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE #
0002608645 12/14/2007

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS.

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to security interest(s) of the Secured Party authorizing this Termination Statement.

3. ☐ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to security interest(s) of the Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law.

4. ☐ ASSIGNMENT (full or partial): Give name of assignee in item 7a or 7b and address of assignee in item 7c; and also give name of assignor in item 9.

5. AMENDMENT (PARTY INFORMATION): This Amendment affects ☒ Debtor or ☐ Secured Party of record. Check only one of these two boxes.

Also check one of the following three boxes and provide appropriate information in items 6 and/or 7.

☐ CHANGE name and/or address: Please refer to the detailed instructions in regards to changing the name/address of a party.

☐ DELETE name: Give record name to be deleted in item 6a or 6b.

☒ ADD name: Complete item 7a or 7b, and also item 7c; also complete items 7e-7g (if applicable).

6. CURRENT RECORD INFORMATION:

6a. ORGANIZATION'S NAME Greater Waterbury Management Resources, Inc.

OR

6b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7. CHANGED (NEW) OR ADDED INFORMATION:

7a. ORGANIZATION'S NAME Alliance Medical Group, Inc.

OR

7b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1625 Straits Turnpike, Suite 211	Middlebury	CT	06762	USA

7d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	7e. TYPE OF ORGANIZATION	7f. JURISDICTION OF ORGANIZATION	7g. ORGANIZATIONAL ID #, if any
		Corporation	CT	0942851 ☐ NONE

8. AMENDMENT (COLLATERAL CHANGE): check only one box.

Describe collateral ☐ deleted or ☐ added, or give entire ☐ restated collateral description, or describe collateral ☐ assigned.

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT (name of assignor, if this is an Assignment). If this is an Amendment authorized by a Debtor which adds collateral or adds the authorizing Debtor, or if this is a Termination authorized by a Debtor, check here ☐ and enter name of DEBTOR authorizing this Amendment.

9a. ORGANIZATION'S NAME Mazuma Capital Corp

OR

9b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

10. OPTIONAL FILER REFERENCE DATA CTSOS-121207-KJ

50822802

FILING OFFICE COPY — UCC FINANCING STATEMENT AMENDMENT (FORM UCC3) (REV. 05/22/02)

[redacted]

UCC FINANCING STATEMENT AMENDMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER [optional]

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

70896198 - 346290

Prepared By:
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703-4261

Filed In: Connecticut (S.O.S.)

FILING #0002906100 PG 01 OF 01 VOL U-00474
FILED 11/13/2012 08:30 AM PAGE 00948
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

FOR FILING OFFICE USE ONLY

1a. INITIAL FINANCING STATEMENT FILE #
0002608645 12/14/2007

1b. ☐ This FINANCING STATEMENT AMENDMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS.

2. ☐ TERMINATION: Effectiveness of the Financing Statement identified above is terminated with respect to security interest(s) of the Secured Party authorizing this Termination Statement.

3. ☒ CONTINUATION: Effectiveness of the Financing Statement identified above with respect to security interest(s) of the Secured Party authorizing this Continuation Statement is continued for the additional period provided by applicable law.

4. ☐ ASSIGNMENT (full or partial): Give name of assignee in item 7a or 7b and address of assignee in item 7c; and also give name of assignor in item 9.

5. AMENDMENT (PARTY INFORMATION): This Amendment affects ☐ Debtor or ☐ Secured Party of record. Check only one of these two boxes.

Also check one of the following three boxes and provide appropriate information in items 6 and/or 7.

☐ CHANGE name and/or address: Please refer to the detailed instructions in regards to changing the name/address of a party. ☐ DELETE name: Give record name to be deleted in item 6a or 6b. ☐ ADD name: Complete item 7a or 7b, and also item 7c; also complete items 7e-7g (if applicable).

6. CURRENT RECORD INFORMATION:

6a. ORGANIZATION'S NAME: Greater Waterbury Management Resources, Inc.

OR

6b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7. CHANGED (NEW) OR ADDED INFORMATION:

7a. ORGANIZATION'S NAME

OR

7b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

7c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

7d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	7e. TYPE OF ORGANIZATION	7f. JURISDICTION OF ORGANIZATION	7g. ORGANIZATIONAL ID #, if any
				☐ NONE

8. AMENDMENT (COLLATERAL CHANGE): check only one box.

Describe collateral ☐ deleted or ☐ added, or give entire ☐ restated collateral description, or describe collateral ☐ assigned.

9. NAME OF SECURED PARTY OF RECORD AUTHORIZING THIS AMENDMENT (name of assignor, if this is an Assignment). If this is an Amendment authorized by a Debtor which adds collateral or adds the authorizing Debtor, or if this is a Termination authorized by a Debtor, check here ☐ and enter name of DEBTOR authorizing this Amendment.

9a. ORGANIZATION'S NAME: Mazuma Capital Corp

OR

9b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

10. OPTIONAL FILER REFERENCE DATA

70896198

FILING OFFICE COPY — UCC FINANCING STATEMENT AMENDMENT (FORM UCC3) (REV. 05/22/02)

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER(optional)
Tim Farina 610-386-5000 Ext-3028

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

Lease Direct
PO Box 4000
Johnston, IA 50131-9854

2893406 pg. 1 of 1
08/27/2012

FILING #00002893406 PG 01 OF 01 VOL U-00469
FILED 08/27/2012 08:30 AM PAGE 01015
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name(1a or 1b) - do not abbreviate or combine names

1a. ORGANIZATION'S NAME: ALLIANCE MEDICAL GROUP, INC.

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1625 STRAITS TPKE STE 211	MIDDLEBURY	CT	06762-1836	USA

1d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		CORPORATION	CT	☒ NONE

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name(2a or 2b) - do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ NONE

3. SECURED PARTY'S NAME (or NAME of Total ASSIGNEE of ASSIGNOR S/P) - insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: CISCO SYSTEMS CAPITAL CRP

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1111 OLD EAGLE SCHOOL ROAD	WAYNE	PA	19087	USA

4. This FINANCING STATEMENT covers the following collateral:

ALL EQUIPMENT LEASED OR FINANCED BY SECURED PARTY TO OR FOR DEBTOR PURSUANT TO SECURED PARTY'S CONTRACT NUMBER 25048119 , TOGETHER WITH ALL ADDITIONS, ATTACHMENTS, ACCESSORIES AND SUBSTITUTIONS TO OR FOR THE SAME, AND ALL PROCEEDS OF THE FOREGOING.

THIS FILING RELATES ONLY TO THE AFOREMENTIONED COLLATERAL, AND IS NOT INTENDED TO CREATE OR PERFECT A LIEN ON ALL OF THE DEBTOR'S ASSETS.

5. ALTERNATIVE DESIGNATION(if applicable): ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA

SOS: 50.00(filing fee)

FILING OFFICE COPY - UCC FINANCING STATEMENT (FORM UCC1) (REV. 05/22/02)

International Association of Commercial Administrators(IACA)

01330330S

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Corporation Service Company 1-866-484-2382

B. E-MAIL CONTACT AT FILER (optional)
SPRFiling@cscinfo.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

80749198 - 378250
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecticut (S.O.S.)

FILING #0002961680 PG 01 OF 02 VOL U-00502
FILED 10/16/2013 08:30 AM PAGE 00674
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME: ALLIANCE MEDICAL GROUP, INC.

OR

1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1625 STRAITS TURNPIKE	MIDDLEBURY	CT	06762	USA

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME: EverBank Commercial Finance, Inc.

OR

3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
10 Waterview Blvd	Parsippany	NJ	07054	USA

4. COLLATERAL: This financing statement covers the following collateral:

All items of personal property leased pursuant to that certain Lease Agreement dated 10/14/2013, by and between EverBank Commercial Finance, Inc. as lessor, rentor or owner and ALLIANCE MEDICAL GROUP, INC. as lessee or customer, as more specifically described below and/or in attachments hereto, together with all related software (embedded therein or otherwise), all additions, attachments, accessories and accessions thereto, whether or not furnished by the supplier thereof; and any and all substitutions, replacements or exchanges for any such item of equipment and any and all insurance and/or other proceeds thereof.

(1) Refurbished FlexFocus 400 Ultrasound System- 19" Monitor; Quantum Basic Software
(1) Power Cable Holder; Endo Transducer Holder; Endo Transducer Holder Mount
(2) Extra Battery Rechargeable
(1) Quantum Basic Upgrade; Dicom Option; 3D Professional; Anorectal 3d Transducer

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and Instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☐ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA: 41002964 - 5 - Healthcare

80749198

FILING OFFICE COPY — UCC FINANCING STATEMENT (Form UCC1) (Rev. 04/20/11)

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

FILING #0002961680 PG 02 OF 02 VOL U-00502
FILED 10/16/2013 08:30 AM PAGE 00675
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

UCC FINANCING STATEMENT ADDENDUM

FOLLOW INSTRUCTIONS

9. NAME OF FIRST DEBTOR: Same as line 1a or 1b on Financing Statement; if line 1b was left blank because individual Debtor name did not fit, check here ☐

9a. ORGANIZATION'S NAME
ALLIANCE MEDICAL GROUP, INC.

OR

9b. INDIVIDUAL'S SURNAME

FIRST PERSONAL NAME

ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

THE ABOVE SPACE IS FOR FILING OFFICE USE ONLY

10. DEBTOR'S NAME: Provide (10a or 10b) only one additional Debtor name or Debtor name that did not fit in line 1b or 2b of the Financing Statement (Form UCC1) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name) and enter the mailing address in line 10c

10a. ORGANIZATION'S NAME

OR

10b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

10c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

11. ☐ ADDITIONAL SECURED PARTY'S NAME or ☐ ASSIGNOR SECURED PARTY'S NAME: Provide only one name (11a or 11b)

11a. ORGANIZATION'S NAME

OR

11b. INDIVIDUAL'S SURNAME | FIRST PERSONAL NAME | ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

11c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

(1) Mobile Keyboard Dock w/Battery for Flex Focus w/2 rechargeable batteries, backpack; illuminited control panel keys; sealed control panel

(1) Water standoff collar; Rectosigmoidoscope w/Obturator for Welch Allyn

(1) Digital B/W Printer Start up Kit - Sony Printer, Printer Paper, USB Cable All additional accessories and services included

13. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS (if applicable)

14. This FINANCING STATEMENT:
☐ covers timber to be cut ☐ covers as-extracted collateral ☐ is filed as a fixture filing

15. Name and address of a RECORD OWNER of real estate described in item 16 (if Debtor does not have a record interest):

16. Description of real estate:

17. MISCELLANEOUS:

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS

A. NAME & PHONE OF CONTACT AT FILER (optional)
Corporation Service Company 1-866-484-2382

B. E-MAIL CONTACT AT FILER (optional)
SPRFiling@cscinfo.com

C. SEND ACKNOWLEDGMENT TO: (Name and Address)

80841667 - 378250
Corporation Service Company
801 Adlai Stevenson Drive
Springfield, IL 62703

Filed In: Connecticu
(S.O.S.

FILING #0002962368 PG 01 OF 02 VOL U-00502
FILED 10/18/2013 08:30 AM PAGE 01811
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR'S NAME: Provide only one Debtor name (1a or 1b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 1b, leave all of item 1 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

1a. ORGANIZATION'S NAME: ALLIANCE MEDICAL GROUP, INC.

OR

1b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1625 STRAITS TURNPIKE	MIDDLEBURY	CT	06762	USA

2. DEBTOR'S NAME: Provide only one Debtor name (2a or 2b) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name); if any part of the Individual Debtor's name will not fit in line 2b, leave all of item 2 blank, check here ☐ and provide the Individual Debtor information in item 10 of the Financing Statement Addendum (Form UCC1Ad)

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

3. SECURED PARTY'S NAME (or NAME of ASSIGNEE of ASSIGNOR SECURED PARTY): Provide only one Secured Party name (3a or 3b)

3a. ORGANIZATION'S NAME: EverBank Commercial Finance, Inc.

OR

3b. INDIVIDUAL'S SURNAME	FIRST PERSONAL NAME	ADDITIONAL NAME(S)/INITIAL(S)	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
10 Waterview Blvd	Parsippany	NJ	07054	USA

4. COLLATERAL: This financing statement covers the following collateral:

All items of personal property leased pursuant to that certain Lease Agreement dated October 14, 2013, by and between EverBank Commercial Finance, Inc. as lessor, rentor or owner and Alliance Medical Group, Inc. as lessee or customer, as more specifically described below and/or in attachments hereto, together with all related software (embedded therein or otherwise), all additions, attachments, accessories and accessions thereto, whether or not furnished by the supplier thereof; and any and all substitutions, replacements or exchanges for any such item of equipment and any and all insurance and/or other proceeds thereof.

(1) Refurbished FlexFocus 400 Ultrasound System- 19" Monitor; Quantum Basic Software
(1) Power Cable Holder; Endo Transducer Holder; Endo Transducer Holder Mount
(2) Extra Battery Rechargeable
(1) Quantum Basic Upgrade; Dicom Option; 3D Professional; Anorectal 3d Transducer

5. Check only if applicable and check only one box: Collateral is ☐ held in a Trust (see UCC1Ad, item 17 and Instructions) ☐ being administered by a Decedent's Personal Representative

6a. Check only if applicable and check only one box:
☐ Public-Finance Transaction ☐ Manufactured-Home Transaction ☐ A Debtor is a Transmitting Utility

6b. Check only if applicable and check only one box:
☐ Agricultural Lien ☐ Non-UCC Filing

7. ALTERNATIVE DESIGNATION (if applicable): ☐ Lessee/Lessor ☐ Consignee/Consignor ☐ Seller/Buyer ☐ Bailee/Bailor ☐ Licensee/Licensor

8. OPTIONAL FILER REFERENCE DATA: 41002964 - 5 - Healthcare

80841667

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

UCC FINANCING STATEMENT ADDENDUM

FOLLOW INSTRUCTIONS

9. NAME OF FIRST DEBTOR: Same as line 1a or 1b on Financing Statement; if line 1b was left blank because Individual Debtor name did not fit, check here ☐

9a. ORGANIZATION'S NAME
ALLIANCE MEDICAL GROUP, INC.

OR

9b. INDIVIDUAL'S SURNAME

FIRST PERSONAL NAME

ADDITIONAL NAME(S)/INITIAL(S)

FILING #0002962368 PG 02 OF 02 VOL U-00502
FILED 10/18/2013 08:30 AM PAGE 01812
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

10. DEBTOR'S NAME: Provide (10a or 10b) only one additional Debtor name or Debtor name that did not fit in line 1b or 2b of the Financing Statement (Form UCC1) (use exact, full name; do not omit, modify, or abbreviate any part of the Debtor's name) and enter the mailing address in line 10c

10a. ORGANIZATION'S NAME

OR

10b. INDIVIDUAL'S SURNAME

INDIVIDUAL'S FIRST PERSONAL NAME

INDIVIDUAL'S ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

10c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

11. ☐ ADDITIONAL SECURED PARTY'S NAME or ☐ ASSIGNOR SECURED PARTY'S NAME: Provide only one name (11a or 11b)

11a. ORGANIZATION'S NAME

OR

11b. INDIVIDUAL'S SURNAME | FIRST PERSONAL NAME | ADDITIONAL NAME(S)/INITIAL(S) | SUFFIX

11c. MAILING ADDRESS | CITY | STATE | POSTAL CODE | COUNTRY

12. ADDITIONAL SPACE FOR ITEM 4 (Collateral):

(1) Mobile Keyboard Dock w/Battery for Flex Focus w/2 rechargeable batteries, backpack; illuminited control panel keys; sealed control panel

(1) Water standoff collar; Rectosigmoidoscope w/Obturator for Welch Allyn

(1) Digital B/W Printer Start up Kit - Sony Printer, Printer Paper, USB Cable All additional accessories and services included

13. ☐ This FINANCING STATEMENT is to be filed [for record] (or recorded) in the REAL ESTATE RECORDS (if applicable)

14. This FINANCING STATEMENT:
☐ covers timber to be cut ☐ covers as-extracted collateral ☐ is filed as a fixture filing

15. Name and address of a RECORD OWNER of real estate described in item 16 (if Debtor does not have a record interest):

16. Description of real estate:

17. MISCELLANEOUS:

Corporation Service Company
2711 Centerville Rd, Ste. 400
Wilmington, DE 19808

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR: Marisol Skibicki at 561
REF. NO: 3274-1135
DATE: 06/30/16
INDEX DATE: 06/17/16
IRS INDEX DATE: 06/23/16
DRC REF. NO: 506519

REGARDING: CARDIOLOGY ASSOCIATES OF GREATER WATERBURY

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There are no presently effective records under the debtor name.

Similar Name Found: Cardiology Associates of Waterbury, P.C. – Waterbury, CT

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR:	Marisol Skibicki at 561
REF. NO:	3274-1135
DATE:	06/30/16
INDEX DATE:	06/17/16
IRS INDEX DATE:	06/23/16
DRC REF. NO:	506519

REGARDING: IMAGING PARTNERS LLC

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There are no presently effective records under the debtor name.

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

A CONFIDENTIAL REPORT BY

Data Reporting Corp.

SEARCH RESULTS

REPORT FOR:	Marisol Skibicki at 561
REF. NO:	3274-1135
DATE:	06/30/16
INDEX DATE:	06/17/16
IRS INDEX DATE:	06/23/16
DRC REF. NO:	506519

REGARDING: VALLEY IMAGING PARTNERS

JURISDICTION: Secretary of the State – Connecticut

A search has been conducted of the records of the Uniform Commercial Code Division to determine if there are presently effective UCC Financing Statements, Municipal Tax Liens, State Tax Liens, Federal Tax Liens, Judgment Notices or other filings of record which name the above-captioned.

[**X**] There are no presently effective records under the debtor name.

If we may be of further assistance, please advise.

330 Roberts Street, Suite 203, East Hartford, CT 06108-3654
Email: datareporting@frontier.com
Tel 800-570-7750 Tel 860-282-0685 Fax 800-672-8635

The information contained in this report is strictly confidential. Although obtained from sources deemed reliable, the accuracy of same is not guaranteed. No liability is assumed by the searcher.

[redacted]

UCC FINANCING STATEMENT

FOLLOW INSTRUCTIONS (front and back) CAREFULLY

A. NAME & PHONE OF CONTACT AT FILER(optional)
Tim Farina 610-386-5000 Ext-3028

B. SEND ACKNOWLEDGMENT TO: (Name and Address)

Lease Direct
PO Box 4000
Johnston, IA 50131-9854

FILING #0002852266 PG 01 OF 01 VOL U-00453
FILED 12/27/2011 08:30 AM PAGE 01515
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name(1a or 1b) - do not abbreviate or combine names

1a. ORGANIZATION'S NAME: VNA HEALTH AT HOME, INCORPORATED

OR

1b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

1c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
27 SIEMON COMPANY DR STE 101W	WATERTOWN	CT	06795-2654	USA

1d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	1e. TYPE OF ORGANIZATION	1f. JURISDICTION OF ORGANIZATION	1g. ORGANIZATIONAL ID #, if any
		CORPORATION	CT	62526 ☐ NONE

2. ADDITIONAL DEBTOR'S EXACT FULL LEGAL NAME - insert only one debtor name(2a or 2b) - do not abbreviate or combine names

2a. ORGANIZATION'S NAME

OR

2b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

2c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY

2d. SEE INSTRUCTIONS	ADD'L INFO RE ORGANIZATION DEBTOR	2e. TYPE OF ORGANIZATION	2f. JURISDICTION OF ORGANIZATION	2g. ORGANIZATIONAL ID #, if any
				☐ NONE

3. SECURED PARTY'S NAME (or NAME of Total ASSIGNEE of ASSIGNOR S/P) - insert only one secured party name (3a or 3b)

3a. ORGANIZATION'S NAME: PHILIPS MEDICAL CAPITAL, LLC.

OR

3b. INDIVIDUAL'S LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

3c. MAILING ADDRESS	CITY	STATE	POSTAL CODE	COUNTRY
1111 OLD EAGLE SCHOOL ROAD	WAYNE	PA	19087	USA

4. This FINANCING STATEMENT covers the following collateral:

ALL EQUIPMENT LEASED OR FINANCED BY SECURED PARTY TO OR FOR DEBTOR PURSUANT TO SECURED PARTY'S CONTRACT NUMBER 101336, TOGETHER WITH ALL ADDITIONS, ATTACHMENTS, ACCESSORIES AND SUBSTITUTIONS TO OR FOR THE SAME, AND ALL PROCEEDS OF THE FOREGOING.

THIS FILING RELATES ONLY TO THE AFOREMENTIONED COLLATERAL, AND IS NOT INTENDED TO CREATE OR PERFECT A LIEN ON ALL OF THE DEBTOR'S ASSETS.

5. ALTERNATIVE DESIGNATION(if applicable): ☐ LESSEE/LESSOR ☐ CONSIGNEE/CONSIGNOR ☐ BAILEE/BAILOR ☐ SELLER/BUYER ☐ AG. LIEN ☐ NON-UCC FILING

6. ☐ This FINANCING STATEMENT is to be filed (or recorded) in the REAL ESTATE RECORDS. Attach Addendum [if applicable]

7. Check to REQUEST SEARCH REPORT(S) on Debtor(s) [ADDITIONAL FEE] [optional] ☐ All Debtors ☐ Debtor 1 ☐ Debtor 2

8. OPTIONAL FILER REFERENCE DATA

SOS 50.00(filing fee)

FILING OFFICE COPY - UCC FINANCING STATEMENT (FORM UCC1) (REV. 05/22/02)

International Association of Commercial Administrators(IACA)

SCHEDULE 3.11(a)

PERMITTED ENCUMBRANCES

A. Waterbury Hospital Main Campus – 64 Robbins Street, 134 Grandview Avenue, 140 Grandview Avenue, 170 Grandview Avenue, Waterbury

Said premises are subject to:

1. a. Real Estate taxes on the October 1, 2015 Grand List, not yet due or payable, and subsequent Grand Lists, as to property known as 64 Robbins Street, which Grantee assumes and agrees to pay as of date of Closing.

   b. Real Estate taxes on the October 1, 2015 Grand List, second installment not yet due and payable, and subsequent Grand Lists, as to property located at 134 Grandview Avenue, 140 Grandview Avenue, and 170 Grandview Avenue, which Grantee assumes and agrees to pay as of date of Closing.

2. Water and Sewer use charges as may be due and payable to City of Waterbury.

3. Notice of Lease between Mattatuck Medical Associates and the Waterbury Hospital dated November 21, 1973 and recorded in Volume 1120 at Page 260; as modified by Amendment to Notice of Lease dated February 15, 1974 and recorded in Volume 1133 at Page 48; as further modified by Second Amendment to Notice of Lease dated January 1, 1977 and recorded in Volume 1308 at Page 120; as further modified by Third Amendment dated December 4, 2001 and recorded in Volume 4272 at Page 344; as further modified by Fourth Amendment dated January 27, 2006 and recorded in Volume 5681 at Page 102 of the Waterbury Land Records.

4. Notice of Sublease from Mattatuck Medical Associates, L.L.P. to Waterbury Hospital dated February 23, 2006 and recorded in Volume 5681 at Page 106 of the Waterbury Land Records.

5. Notice of Lease between Waterbury Medical Associates N/K/A Waterbury Medical Associates, L.L.P. and The Waterbury Hospital dated November 1, 1977 and recorded in Volume 1308 at Page 124; as modified by Corrected Notice of Lease dated September 30, 1986 and recorded in Volume 1962 at Page 337 of the Waterbury Land Records.

6. Notice of Lease from the Waterbury Hospital to Cellco Partnership dated February 7, 1997 and recorded in Volume 3481 at Page 62 of the Waterbury Land Records.

7. Notice of Lease from Waterbury Hospital to The Children's Center of Greater Waterbury Health Network, Inc. dated August 1, 2000 and recorded in Volume 4016 at Page 131 of the Waterbury Land Records.

8. Notice of Lease from Waterbury Hospital to WPA Properties, LLC dated October 3, 2000 and recorded in Volume 4042 at Page 334 of the Waterbury Land Records.

9. Open-End Leasehold Mortgage from WPA Properties, LLC to Naugatuck Savings Bank in the original principal amount of □535,000.00, dated October 6, 2000 and recorded in Volume 4043 at Page 1; as modified by Loan Modification Agreement dated May 21, 2001 and recorded in Volume 4172 at Page 66; as further modified by Second Loan Modification Agreement dated February 5, 2002 and recorded in Volume 4323 at Page 74 of the Waterbury Land Records.

10. Assignment of Leases and Rents to Naugatuck Savings Bank dated October 3, 2000 and recorded in Volume 4043 at Page 22 of the Waterbury Land Records.

11. Notice of Lease from Mattatuck Medical Associates, L.L.P. to Waterbury Hospital dated November 1, 2001 and recorded in Volume 4273 at Page 42 of the Waterbury Land Records.

12. Lease Ratification, Cure, Attornment, Subordination and Non-Disturbance Agreement dated December 7, 2001 and recorded in Volume 4273 at Page 45 of the Waterbury Land Records.

13. Easement to The Connecticut Light and Power Company dated June 21, 1974 and recorded in Volume 1148 at Page 235 of the Waterbury Land Records.

14. Declaration of Easements, Rights and Restrictions dated November 1, 1977 and recorded in Volume 1308 at Page 130 of the Waterbury Land Records.

15. Easement to The Connecticut Light and Power Company dated June 30, 1978 and recorded in Volume 1332 at Page 168 of the Waterbury Land Records.

16. Special Exception dated March 23, 1988 and recorded in Volume 2264 at Page 218 of the Waterbury Land Records.

17. Easement to the City of Waterbury dated October 13, 1993 and recorded in Volume 3021 at Page 216 of the Waterbury Land Records.

18. Variance dated September 16, 1997 and recorded in Volume 3527 at Page 137 of the Waterbury Land Records.

19. Special Exception dated June 22, 1999 and recorded in Volume 3839 at Page 343 of the Waterbury Land Records.

20. Special Exception dated April 18, 2000 and recorded in Volume 3987 at Page 44 of the Waterbury Land Records.

21. Variances dated June 22, 2000 and recorded in Volume 3993 at Page 25 and 26 of the Waterbury Land Records.

22. Special Exception dated June 22, 2000 and recorded in Volume 4005 at Page 209 of the Waterbury Land Records.

23. Variance dated June 22, 2000 and recorded in Volume 4005 at Page 210 of the Waterbury Land Records.

24. Site Plan dated August 3, 2000 and recorded in Volume 4043 at Page 329 of the Waterbury Land Records.

25. Easement dated May 14, 1917 and recorded in Volume 282 at Page 177 of the Waterbury Land Records.

26. Rights set forth in a Deed dated October 15, 1925 and recorded in Volume 372 at Page 445 of the Waterbury Land Records.

27. Rights and Right-of-Way set forth in a Deed dated November 12, 1952 and recorded in Volume 667 at Page 445 of the Waterbury Land Records.

28. Right-of-Way in favor of the City of Waterbury dated November 3, 1928 and recorded in Volume 412 at Page 697 of the Waterbury Land Records.

29. Right-of-Way in favor of the City of Waterbury dated April 19, 1944 and recorded in Volume 533 at page 421 of the Waterbury Land Records.

30. Rights of others to pass and repass over property located within the limits of so-called Carter Avenue, Hale Street and Winthrop Terrace, as said Streets are shown on a certain map entitled "Map of Woodside, Waterbury, Conn. dated at Waterbury, Ct. March 1, 1902," prepared by A.J. Patton, Surveyor; which map is recorded in the Waterbury Town Clerk's Office as Map Book 1 Page 25.

31. Rights set forth in a certain Certificate of Taking, State of Connecticut, dated March 21, 1963 and recorded in Volume 842 at Page 30 of the Waterbury Land Records, and set forth in a Deed dated June 7, 1963 and recorded in Volume 847 at Page 397 of the Waterbury Land Records. (Note: The maps recited in these instruments are not filed of record.)

32. Matters as shown on a certain unfiled map entitled "Site Development Plan For Medical Building Land of Waterbury Hospital Grandview Ave. Waterbury, Conn. Scale 1" = 40' Date 3/29/77 (with five revisions to 12/22/77)," prepared by Paul Associates and recorded in the Waterbury Land Records in Volume 1308 at Page 152 of the Waterbury Land Records.

33. Rights of others to pass and repass over property which may be located in an area shown as "Drive" and rights of others to park on property which may be located within an area shown as "Parking Lot," as shown on a map entitled "Map Showing Land to be Leased by Waterbury Hospital Waterbury, Conn. Aug. 17, 1973 Revised Sept. 4, 1973;" which map is not on file in the Waterbury Town Clerk's Office.

34. Certificate of Approval issued by the Waterbury "oning Board of Appeals dated April 27, 2010 and recorded in Volume 6693 at Page 166 of the Waterbury Land Records.

35. Leasehold Mortgage from Waterbury Medical Associates, L.L.P. to Wells Fargo Bank, National Association in the original principal amount of □1,139,027.95, dated August 29, 2014 and recorded in Volume 7215 at Page 88 of the Waterbury Land Records.

36. UCC Financing Statement in favor of Wells Fargo Bank, National Association recorded May 12, 2014 in Volume 7215 at Page 116 of the Waterbury Land Records.

37. Leasehold Mortgage from Mattatuck Medical Associates, LLP to Berkshire Bank in the original principal amount of □1,850,000.00, dated June 16, 2015 and recorded in Volume 7361 at Page 1 of the Waterbury Land Records.

38. UCC Financing Statement in favor of Berkshire Bank recorded June 23, 2015 in Volume 7361 at Page 43 of the Waterbury Land Records.

39. Unrecorded leases and tenants in possession.

40. Matters as shown by survey:

    a. Certain retaining walls meander along and over boundary lines at various points.

    b. Fencing crosses boundary lines at various points.

    c. Improvements located within limits of so-called Carter Avenue, Hale Street, and Winthrop Terrace (also known as Winfield Terrace).

B. <u>36 Grandview Avenue, Waterbury</u>

Property is subject to:

1. Real Estate taxes on the October 1, 2015 Grand List, not yet due or payable, and subse□uent Grand Lists, which Grantee assumes and agrees to pay as of date of Closing.
2. Water and Sewer use charges as may be due and payable to the City of Waterbury.
3. The following matter as shown by survey:
    a. Garage encroachment over easterly boundary line onto abutting property.

C. <u>305 Church Street Condominium, Unit 7, 305 Church Street, Naugatuck</u>

Said premises are subject to:

1. Real Estate taxes to the Town of Naugatuck, on the Grand List of October 1, 2015. First half paid, second half not yet due and payable, and subse□uent Grand Lists, which the Grantee assumes and agrees to pay as of date of Closing.
2. Water and sewer use charges as may be due.
3. Terms, Conditions, Agreements, Covenants, Restrictions, Obligations and Easements contained in the Declaration of Condominium described herein and the By-laws and Exhibits made a part of said Declaration of Condominium, and any amendments or modifications subse□uently made thereto.

4. Assessments for common expenses or common charges assessed as provided for in Section 59 of the Common Interest Act against the herein described premises. Payments are current.
5. Passway rights over a 5 foot wide strip of land located southernmost described herein, and the right of the Goodyear India Rubber Glove Manufacturing Co. as set forth in deed to Patrick Brennan, dated and recorded December 29, 1888 in Volume 21 at Page 561 of the Naugatuck Land Records.
6. Easement from Harris Whittemore to United Electric Light and Water Company dated June 25, 1914 and recorded July 24, 1914 in Volume 56 at Page 137 of the Naugatuck Land Records.
7. Possible Storm Sewer Easement (not of record) mentioned in deed from Estate of Harris Whittemore to The Colonial Bank and Trust Company, Trustee, dated January 5, 1929 and recorded January 9, 1929 in Volume 78 at Page 290 of the Naugatuck Land Records.
8. An easement from Uniroyal, Inc. to Professional Park, Inc. recorded on October 20, 1970 in Volume 161 at Page 140 of the Naugatuck Land Records.
9. Restrictions as to use as set forth in a certain Warranty Deed from Professional Park to Greater Waterbury Management Resources, Inc. dated and recorded January 13, 1989 in Volume 326 at Page 646 of the Naugatuck Land Records.
10. Matters shown by survey:
    a. Building on First Piece of 305 Church Street Condominium encroaches slightly on the south side thereof onto strip of land affected by passway rights per Volume 21, Page 561 of the Naugatuck Land Records.
    b. Building referenced in a. above crosses over street and rear setback lines.
    c. Rock xeriscaping along Church Street frontage crosses into Church Street right of way.
    d. Asphalt on southerly side of First Piece of 305 Church Street Condominium encroaches over adjoining parcel and asphalt on easterly side of Second Piece of 305 Church Street Condominium encroaches into Water Street right of way.
    e. Curbing and gravel beds on southerly side of Second Piece of 305 Church Street Condominium cross over boundary line.
    f. Dirt drive on northerly side of Second Piece of 305 Church Street Condominium crosses over boundary line from adjoining parcel.
    g. 4-foot high metal fence at northwesterly corner of First Piece of 305 Church Street Condominium crosses over boundary line.

SCHEDULE 3.11(b)

REAL PROPERTY DISCLOSURES

[REDACTED PER CONN. GEN. STAT. 1-210(b)(5)]

SCHEDULE 3.12

ENVIRONMENTAL CLAIMS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.13

INTELLECTUAL PROPERTIES AND INFORMATION SYSTEMS

See Schedule 2.01(h)

SCHEDULE 3.14

INSURANCE

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.15

PERMITS NOT IN GOOD STANDING

For Greater Waterbury Health Network, Inc.:

None.

For Waterbury Hospital:

None.

For Alliance Medical Group:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For VNA Health at Home, Inc.:

None.

For Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 3.16(a)

GOVERNMENT PAYMENT PROGRAMS AND ACCREDITATION

For The Waterbury Hospital:

The Joint Commission accreditation from June 14, 2016 - June 13, 2019

Greater Waterbury Health Network, Inc.

None.

For Alliance Medical Group, Inc.

None.

For Cardiology Associates of Greater Waterbury, LLC

None.

For VNA Health at Home, Inc.

None.

For Greater Waterbury Management Resources, Inc.

None.

SCHEDULE 3.16(b)

COST REPORTS

For The Waterbury Hospital

See attached.

Greater Waterbury Health Network, Inc.

None.

For Alliance Medical Group, Inc.

None.

For Cardiology Associates of Greater Waterbury, LLC

None.

For VNA Health at Home, Inc.

None.

For Greater Waterbury Management Resources, Inc.

None.

Waterbury Hospital
Closing Documents

Schedule 3.16(b)-Cost Reports

		Medicare			Medicaid
		IP and OP Settlement	Meaningful Use Monies	Total	
FY 2016	To be filed 5 months after closing date				Not applicable-payments now under APR-DRGs
FY 2015	Filed 02/26/2016	$747,347	$600,563	$1,347,910	Medicaid cost report for the period of 10/1/14 to 12/31/14 filed on 06/17/2016. Amount due hospital is $433,851. No cost report settlement after 12/31/14, due to APR-DRG.
	Tentative settment issued 03/30/016	$747,347		$747,347	
	MU monies received April 2016		$600,563	$600,563	
	Current balance based on filing	$0	$0	$0	
FY 2014	Filed 02/26/2015	$1,389,935	$152,874	$1,542,809	Medicaid cost reports prior to FY 2015 have been filed and monies received. The State has not in the past "settled" the cost reports once the Medicare cost report has been finalized.
	Tentative settlement 04/24/2015	$1,349,460		$1,349,460	
	MU monies received 03/27/2015		$152,874	$152,874	
				$0	
	Adjustment to bad debts as part of the initial desk review notificiation (12/22/2015)*	-$237		-$237	
				$0	
	Current balance based on filings	$40,475	$0	$40,475	
	*Received desk review letter dated 12/01/2015. No review work has commenced yet, to our knowledge				
Appeals	See separate listing attached regarding appeal items All the listed appeals are being handled by Quality Reimbursement Services, Inc.				See separate listing attached regarding appeal items

NPR	Appeal		Est'd $ Impact	Provider Postion Paper	NGS Position Paper	Case #	FYE		Group appeal		Issue #	Issues
	6/12/2003	12/12/2003		4/28/2004		04-0467	9/30/1996					
	5/22/2003	11/18/2003		3/24/2004	4/28/2004	04-0146	9/30/1997					
	5/23/2003	11/18/2003		3/24/2004		04-0147	9/30/1998					
	9/16/2003	3/2/2004		6/15/2004		04-0794	9/30/1999					
	12/16/2003	5/19/2004		8/18/2004	9/23/2004	04-1709	9/30/2000					
	12/16/2004	5/25/2005		8/2/2005		05-1593	9/30/2001					
	10/7/2005	3/21/2006		6/20/2006	7/26/2006	06-1273	9/30/2002					
	7/3/2006	12/28/2006				07-0585	9/30/2003					
	6/21/2007	12/5/2007		3/18/2008	4/17/2008	08-0341	9/30/2004	*				
	1/25/2008	07/17/2008 (initial filing)				08-2365	9/30/2005		transfer to group appeal		4,000	1 Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
		10/1/2008 (add on issues)	580,000								153,000	2 Disproportionate Share Hospital Payment – Medicaid Eligible Days
									transfer to group appeal		9,000	3 Disproportionate Share Hospital/Supplemental Security Income (Systemic Errors)
											181,000	4 Disproportionate Share Hospital Payment – Medicaid Eligible Days
									transfer to group appeal		51,000	5 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
									transfer to group appeal		20,000	6 Disproportionate Share Hospital Payment –Dual Eligible Days
									transfer to group appeal		40,000	7 Disproportionate Share Hospital Payment –Dual Eligible Days (Exhausted Part A Benefit Days)
									transfer to group appeal		104,000	8 Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment
											115,000	*9* Medicare Crossover Bad Debts
											33,000	*10* Medicare Charity Care Bad Debts
									withdrawn by Provider		15,000	*11* Disproportionate Share Hospital Payment - Medicaid Eligible Observation Bed Days
									transfer to group appeal		3,000	*12* Disproportionate Share Hospital Payment -Exclusion of Part C Days from the Denominatorof the Medicare Percentage
									Note-proposed Joint Scheduling order was issued in Feburary 2009 for items # 2,4,9,10.			
	9/10/2008	3/16/2009	560000			09-1062	9/30/2006	*	transfer to group appeal	09-1003G	3,000	1 Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
											163,000	2 Disproportionate Share Hospital Payment – Medicaid Eligible Days
									transfer to group appeal	09-0993G	3,000	3 Disproportionate Share Hospital/Supplemental Security Income (Systemic Errors)
											3,000	4 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
											20,000	5 Disproportionate Share Hospital Payment – Medicaid Eligible Days
									transfer to group appeal	09-0996G	27,000	6 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
											19,000	7 Disproportionate Share Hospital Payment –Dual Eligible Days
									transfer to group appeal	09-1002G	37,000	8 Disproportionate Share Hospital Payment –Dual Eligible Days (Exhausted Part A Benefit Days)
									transfer to group appeal	08-2169GC	304,000	9 Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment
	9/19/2012	3/6/2013	399,000	10/14/2013	2/24/2014	13-0969	9/30/2007	*			61,000	1 Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
									transfer to group appeal	13-2679G		2 Disproportionate Share Hospital/Supplemental Security Income (Systemic Errors)
											170,000	3 Disproportionate Share Hospital Payment – Medicaid Eligible Days
									transfer to group appeal	13-2676G		4 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
									transfer to group appeal	13-2677G		5 Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days
									transfer to group appeal	13-2678G		6 Disproportionate Share Hospital Payment –Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									transfer to group appeal	13-3416G		7 Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment
	10/26/2012	4/11/2013	644,000	11/1/2013		13-1695	9/30/2008	*			85,000	1 Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
											85,000	2 Disproportionate Share Hospital/Supplemental Security Income (Systemic Errors)
											324,000	3 Disproportionate Share Hospital Payment – Medicaid Eligible Days
											65,000	4 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
											30,000	5 Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days
											33,000	6 Disproportionate Share Hospital Payment - Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
											27,000	7 Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment
	5/2/2013	10/22/2013	501,000			14-0275	9/30/2009	*			34,000	1 Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
											35,000	2 Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
											69,000	3 Disproportionate Share Hospital/Supplemental Security Income (Systemic Errors)
											245,000	4 Disproportionate Share Hospital Payment – Medicaid Eligible Days
											51,000	5 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
											23,000	6 Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days
											26,000	7 Disproportionate Share Hospital Payment - Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
											20,000	8 Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment
	4/25/2014	10/9/2014	534,000	5/26/2015	9/16/2015	15-0061	9/30/2010				80,000	1 Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
									transfer to group appeal	15-2384G		2 Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")
									transfer to group appeal	15-2387G		3 Disproportionate Share Hospital Payment – SSI Fraction/Medicare Managed Care Part C Days
									transfer to group appeal	15-2385G		4 Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									transfer to group appeal	15-2388G		5 Disproportionate Share Hospital Payment – Medicaid Fraction/Medicare Managed Care Part C Days
									transfer to group appeal	15-2386G		6 Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
											147,000	7 Disproportionate Share Hospital Payment – Medicaid Eligible
									transfer to group appeal	15-2388G		8 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
									transfer to group appeal	15-2386G		9 Disproportionate Share Hospital Payment - Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									transfer to group appeal	14-4130G		10 Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment

NPR	Appeal	Est'd $ Impact	Provider Postion Paper	NGS Position Paper	Case #	FYE		Group appeal		Issue #	Issues
10/27/2014 11/11/2014 (revised)	4/21/2015	772,000	12/21/2015	4/27/2016	15-2391	9/30/2011			72,000	1	Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
							transfer to group appeal	15-3037G		2	Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")
							transfer to group appeal	15-3032G		3	Disproportionate Share Hospital Payment – SSI Fraction/Medicare Managed Care Part C Days
							transfer to group appeal	15-3039G		4	Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
							transfer to group appeal	15-3038G		5	Disproportionate Share Hospital Payment – Medicaid Fraction/Medicare Managed Care Part C Days
							transfer to group appeal	15-3031G		6	Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									359,000	7	Disproportionate Share Hospital Payment – Medicaid Eligible Days
							transfer to group appeal	15-3032G and 15-3038G		8	Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
							transfer to group appeal	15-3039G and 15-3031G		9	Disproportionate Share Hospital Payment - Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
							transfer to group appeal	15-2667G		10	Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment
3/30/2015	9/18/2015	766,000	5/24/2016	Due 10/1/16 from FI	15-3409	9/30/2012			69,000	1	Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
							transfer to group appeal	15-1416G		2	Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")
							transfer to group appeal	15-1423G		3	Disproportionate Share Hospital Payment – SSI Fraction/Medicare Managed Care Part C Days
							transfer to group appeal	15-1419G		4	Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
							transfer to group appeal	15-0020G		5	Disproportionate Share Hospital Payment – Medicaid Fraction/Medicare Managed Care Part C Days
							transfer to group appeal	15-0018G		6	Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									370,000	7	Disproportionate Share Hospital Payment – Medicaid Eligible Days
							transfer to group appeal	15-0020G		8	Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
							transfer to group appeal	15-0018G		9	Disproportionate Share Hospital Payment - Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
							transfer to group appeal	16-0628G		10	Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment
12/28/2015	6/17/2016	709,000	Not Filed Yet		Not assigned yet	9/30/2013			29,000	1	Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
									30,000	2	Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")
									29,000	3	Disproportionate Share Hospital Payment – SSI Fraction/Medicare Managed Care Part C Days
									29,000	4	Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									29,000	5	Disproportionate Share Hospital Payment – Medicaid Fraction/Medicare Managed Care Part C Days
									29,000	6	Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									349,000	7	Disproportionate Share Hospital Payment – Medicaid Eligible Days
									69,000	8	Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days
									36,000	9	Disproportionate Share Hospital Payment - Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
									18,000	10	Disproportionate Share – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment

* Letters filed 7/18/14 responding to PRRB Alert 10 where the Board requested that the Provider demonstrate practical impediments as to why all DSH/Medicaid Eligible Days could not be claimed in the Provider's cost report.

Waterbury Hospital
Medicaid Appeals

Initial Notice	Detail		$ amount
4/29/2014	**7/18/2014**	**Rate Appeal** **-IP FY14** **-OP 7/12 to 6/13** State filed a motion to dismiss on 9/28/15 (IP appeal) State filed a motion to dismiss on 9/21/15 (OP appeal). Waterbury filed a request for partial reconsideration regarding the motion to dismiss 10/05/15	
12/15/2014	**3/5/2015**	**IP APR-DRG appeal (effective 1/1/15)**	
1/5/2015	**3/26/2015**	**OP Rate appeal** **-OP 7/13 to 6/14** **-OP 7/14 to 6/15** State filed a motion to dismiss on 10/20/15 (OP appeal), Waterbury filed a request for reconsideration regarding the motion to dismiss on 12/7/15	
7/14/2015	**10/5/2015**	**OP rate appeal 7/15 to 6/16**	
9/2/2015	**11/19/2015**	**Contested Hearing-Dual eligible deductible/copay partial payment recoupment (7/11 to 6/14)**	385,044
10/15/2015	**1/6/2016**	**Request for hearing-State withhold of DSH/Supplemental payments for SFY16**	11,139,267
10/23/2015		**Request for hearing-Tax determination (as it relates to taxes due even after the state DSH payments recinded)**	12,421,400
10/29/2015	**1/13/2016**	**Full Tax refund claim for 3 years (10/12 to 10/15)** State issued a Notice of Proposed Disallowance 1/28/16. Waterbury filed a protest of the disallowance on 3/23/16- requested a full refund, but at a minimum a refund of $1,546,212 for services that should not have been taxed CHA filed a petition for declaratory ruling to the State 11/15/15 CHA filed a memorandum in support of petition for declaratory ruling 06/15/2016	27,968,558

SCHEDULE 3.17

CONTRACTS RELATED TO THE HOSPITAL BUSINESSES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.18

CONSENT, ASSIGNMENT AND PROHIBITIONS ON COMPETITION

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.19

TRANSACTIONS WITH AFFILIATES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.20(a)

PENDING LABOR DISPUTES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.20(b)

COLLECTIVE BARGAINING AGREEMENTS

For The Waterbury Hospital:

Nurses CBA between Seller and Connecticut Health Care Associates covering registered nurses and licensed practical nurses effective October 1, 2013 through September 30, 2017.

Technical Unit CBA between Seller and Connecticut Health Care Associates covering technical employees effective December 9, 2015 through September 30, 2018.

Service & Maintenance CBA between Seller and New England Health Care Employees Union, District 1199 effective May 23, 2016 through February 28, 2017.

SCHEDULE 3.20(c)

EMPLOYMENT MATTERS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.20(d)

RECENTLY TERMINATED EMPLOYEES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.20(f)

PENDING IMMIGRATION PROCEEDINGS

For Greater Waterbury Health Network, Inc.:

None.

For Waterbury Hospital:

None.

For Alliance Medical Group:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For VNA Health at Home, Inc.:

None.

For Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 3.21(a)

EMPLOYEE BENEFIT PLANS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.21(c)

EMPLOYEE BENEFIT PLANS COMPLIANCE AND ISSUES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.22

PROCEEDINGS AND CLAIMS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.24

MATERIAL MEDICAL STAFF DISPUTES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.25

RESTRICTED ASSETS

For Greater Waterbury Health Network, Inc.:

None.

For Waterbury Hospital:

None.

For Alliance Medical Group:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For VNA Health at Home, Inc.:

None.

For Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 3.28

JOINT VENTURES AND CONVERTED VENTURES

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 3.29

MATERIAL TANGIBLE ASSETS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

SCHEDULE 6.03

EXCEPTIONS TO NON-COMPETES

For Greater Waterbury Health Network, Inc.:

None.

For Waterbury Hospital:

None.

For Alliance Medical Group:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For VNA Health at Home, Inc.:

None.

For Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 6.09

CHARITY CARE AND COMMUNITY OBLIGATIONS

See attached.

POLICY: CHARITY CARE		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 3
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 12/5/97 (From PAFS manual)
LAST REVIEWED: 8/15	LAST REVISED: 8/13	RETIRED:

SCOPE: Determination of when charity care is appropriate.
PURPOSE: To make provisions for situations in which charity care is appropriate based on aggregate balance and Encounter review.

POLICY: It is the policy of Waterbury Hospital to appropriately offer charity care in situations where the responsible party for the balance due does not have the financial resources necessary to satisfy their obligation within a reasonable period of time.

1. All patients who request consideration for charity care will be required to apply for public assistance in addition to completing a charity care application unless identified as ineligible by a qualified case worker.

2. In order to be considered for charity care, full financial disclosure is required including:
   a. All sources of income available at the time of application;
   b. Assets excluding;
      i. Primary Residence;
      ii. Vehicles required for commuting to or facilitating employment;
      iii. Retirement Accounts.

3. Responsible parties with assets of $7,500 or less ($15,000 for a couple) will receive the following discounts based on their annual household income and the published federal poverty guidelines in effect at the date of application:

Income as a % of FPL	Discount
200%	100%
225%	60%
275%	40%
300%	20%
400%	10%

4. Charity care discounts are to be applied after the 50% uninsured discount from charges.

5. Documentation required to validate declarations made on the charity care application shall include:
   a. A credit report;
   b. Most recent 1040 tax return;
   c. Copies of all bank statements to include but not limited to:
      i. Checking accounts;
      ii. Savings accounts;
      iii. Investment accounts;
      iv. Certificates of deposit
   d. Proof of income for the immediate 12 months preceding the application date.
   e. Public assistance determination.

PROCEDURE:

1. The availability of charity care will be disclosed on all dunning notices issued prior to bad debt assignment.

2. Patients who indicate they are unable to pay for services rendered will be offered charity care;

3. Financial Counselors shall evaluate each applicant's eligibility.

4. Accounts determined to be eligible for charity care discounts shall re□uire the following authori□ation based on amount to be adjusted:
    a. PAFS Manager □ □5,000
    b. PAFS Director □5,000 or more
    c. Chief Financial Officer □10,000 or more

5. Patients shall be issued a determination letter within 30 days of receipt of a completed charity care application.

6. Patients who do not apply for or do not □ualify for charity care will be expected to pay the balance due. For uninsured patients, this will be e□uivalent to 50□ of charges. Insured patients will be expected to pay any deductible or co-payment due in addition to 50□ of non-covered charges.

7. Patient who do not enter into a payment plan or pay satisfy the balance due will be placed with a collection agency for further collection efforts. The collection agency may report the balance due to credit reporting bureaus and□or initiate legal action to resolve the debt.

Approved: _____ _____
Mark Sammartano Date
Director, PAFS

Approved: _____ _____
Jim Moylan Date
CFO VP Finance

SCHEDULE 8.02(e)

GRANTS

For Greater Waterbury Health Network, Inc.:

None.

For Waterbury Hospital:

None.

For Alliance Medical Group:

None.

For Cardiology Associates of Greater Waterbury, LLC:

None.

For VNA Health at Home, Inc.:

None.

For Greater Waterbury Management Resources, Inc.:

None.

SCHEDULE 8.06

CONSENTS TO ASSIGNMENT OF ASSUMED CONTRACTS

[REDACTED PER CONN. GEN. STAT. □1-210(b)(5)]

Annex A

Calculation Methodology for Net Working Capital

Annex A

An example of the methodology for calculating the net working capital (Greater Waterbury Health Network, Inc.)

	Balance Sheet as of 8/31/2016 (Ownership Adjusted)	Pro Forma	
		Retained by Surviving Entity	Purchased/ Assumed by Prospect
WC Current Assets			
Cash and Cash Equivalents	$ 24,213,063	$ 24,204,984	$ 8,079
Short-term Investments	$ 1,614,621	$ 1,614,621	$ -
Net Accounts Receivable - Patients	$ 29,795,257	$ 118,304	$ 29,676,953
Accounts Receivable - Malpractice	$ 143,176	$ 143,176	$ -
Grants Receivable	$ 2,127,270	$ -	$ 2,127,270
Unexpended Grants	$ (3,849,276)	$ -	$ (3,849,276)
Workers' Comp Excess Receivable	$ 3,762,073	$ 3,762,073	$ -
Other Accounts Receivable	$ 1,439,580	$ -	$ 1,439,580
Inventories	$ 3,405,527	$ -	$ 3,405,527
Prepaid Insurance	$ 530,246	$ 385,025	$ 145,221
Prepaid Other Expense	$ 1,788,118	$ 16,010	$ 1,772,108
Due From Affiliates	$ (717,423)	$ (717,423)	$ -
Total WC Current Assets	**$ 64,252,232**	**$ 29,526,770**	**$ 34,725,462**
WC Current Liabilities			
CP of Sodexo Liability	$ 184,674	$ 184,674	$ -
CP of Accrued Workers' Comp	$ 2,411,328	$ 2,411,328	$ -
CP of Accrued Malpractice	$ 9,636	$ 8,576	$ 1,060
CHCA Pension Contribution (1)	$ (3,000,000)	$ -	$ (3,000,000)
CP of Accrued Pension Liability (2)	$ (3,867,000)	$ -	$ (3,867,000)
Other Accounts Payable and Accrued Expenses	$ 26,618,260	$ 139,480	$ 26,478,780
Total WC Current Liabilities	**$ 22,356,899**	**$ 2,744,059**	**$ 19,612,840**
Net Working Capital			**$ 15,112,622**

Source: Excel File "GWHN-Net Proceeds Opening BS - August 2016.xlsx"
Tab 2 "Net Proceeds - 08.31.2016"

(1) Not included in source file listed above
(2) Included in Other Accounts Payable and Accrued Expenses

EXECUTION VERSION

BYLAWS

OF

PROSPECT WATERBURY, INC.

(a Connecticut corporation)

Adopted October 1, 2016

ARTICLE I

APPLICABILITY

Section 1. APPLICABILITY OF BYLAWS. These Bylaws govern, except as otherwise required by statute or provided in its Certificate of Incorporation, the management of the business and the conduct of the affairs of Prospect Waterbury, Inc. (the "Corporation").

Section 2. CORPORATE PURPOSE. The Corporation's purposes shall include, without limitation, the ownership and operation of a general acute care hospital, known as the Waterbury Hospital (the "Hospital"), and to undertake all activities related thereto. The Hospital shall support, manage and furnish facilities, personnel and services, provide diagnosis, medical, surgical and hospital care, outpatient care and other hospital and medically related services to sick, injured or disabled persons, and to provide well care programs as appropriate and feasible, without regard to patients' race, color, sex, age, national origin or disability, or in any other manner in violation of applicable law.

ARTICLE II

OFFICES

The registered office of the Corporation shall be in the City of Hartford, County of Hartford, State of Connecticut or such other place within the State of Connecticut as the Board of Directors of the Corporation (the "Board") may designate. The Corporation may also establish and have other offices within or without the State of Connecticut, as the Board may designate or its business may require. The Board may change any office from one location to another or eliminate any office or offices.

ARTICLE III

SHAREHOLDERS

Section 1. LOCATION OF MEETINGS. Meetings of the shareholders shall be held at the registered office of the Corporation in Connecticut, or at such other place, within or without the State of Connecticut, as may be designated by the Board and stated in the notice of the meeting.

Section 2. ANNUAL MEETINGS. The annual meeting of the shareholders of the Corporation shall be held for the purpose of electing directors and for the transaction of all other business that is properly brought before the meeting in accordance with these Bylaws on such date and at such time as shall be designated by the Board and as stated in the notice of meeting.

Section 3. SPECIAL MEETINGS. Special meetings of the shareholders may be called by the CEO, a majority of the Board, or, upon written re□uest to the Secretary as set forth below, by the holder or holders of not less than ten percent (10□) of all the shares of common stock (□Shares□) entitled to vote at a meeting. Any such special meeting of shareholders may be held at the principal business office of the Corporation or at such other place or places, either within or without the State of Connecticut, as may be specified in the notice. Business transacted at any special meeting of shareholders of the Corporation shall be limited to the purpose stated in the notice.

(a) SPECIAL MEETINGS REQUESTED BY SHAREHOLDERS. The written re□uest to the Secretary for a special meeting by the holder or holders of not less than ten percent (10□) of all the Shares entitled to vote at a meeting shall be signed by each shareholder, or duly authori□ed agent, re□uesting the special meeting and shall set forth: (i) the name and address of the shareholder or shareholders; (ii) the number of Shares held by the shareholder or shareholders; (iii) the name in which all such Shares are registered on the stock transfer books of the Corporation; (iv) a brief description of the business desired to be brought before the meeting and the reasons therefore; (v) any personal or other material interest of any such shareholder in the business to be submitted; and (vi) all other information relating to the proposed business which may be re□uired to be disclosed under applicable law. In addition, a shareholder seeking to submit such business at an annual meeting shall promptly provide any other information reasonably re□uested by the Corporation. A shareholder may revoke the re□uest for a special meeting at any time by written revocation delivered to the Secretary, and if, following such revocation, there are un-revoked re□uests from shareholders holding in the aggregate less than the re□uisite number of Shares entitling the shareholders to re□uest the calling of a special meeting, the Board, in its discretion, may cancel the special meeting.

Section 4. NOTICE OF MEETINGS. Written notice of all meetings shall be given, which shall state the place, if any, date, and hour of the meeting, the means of remote communication, if any, by which shareholders and proxy holders may be deemed to be present in person and vote at such meeting, and in the case of a special meeting, the purpose or purposes for which the meeting is called in accordance with Article III, Section 3(a) above. The notice of an annual meeting shall state that the meeting is called for the election of directors and for the transaction of other business which may properly come before the meeting, and shall (if any other action which could be taken at a special meeting is to be taken at such annual meeting) state the purpose or purposes. The notice of any meeting shall also include, or be accompanied by, any additional statements, information, or documents prescribed by the law. Written notice of all meetings of the shareholders shall be mailed to a delivered to each of shareholder by the Corporation, not less than ten (10) days and not more than sixty (60) days prior to the meeting.

(a) SERVICE OF NOTICE. Notice by paper mail shall be deemed to be given when deposited, with postage thereon prepaid, in a post office or official depository under the exclusive care and custody of the United States post office department, FedEx, UPS, DHL or

a similarly categori□ed delivery agent. Notice by electronic mail (e-mail) shall be deemed to be given when the message is dispensed from the sender□s computer. If mailed, either by paper or electronically, the notice shall be directed to the shareholder at his or her address as it appears on the records of the stock transfer agent.

(b) ACTUAL OR CONSTRUCTIVE WAIVER OF NOTICE. Notice of a meeting need not be given to any shareholder who submits a signed waiver of notice before or after the meeting. The attendance of a shareholder at a meeting without protesting prior to the conclusion of the meeting the lack of notice of such meetings shall constitute a waiver of notice by him.

Section 5. FIXING DATE FOR DETERMINATION OF SHAREHOLDERS OF RECORD. The Board may fix in advance, a date, not less than ten (l0) but not more than sixty (60) days preceding the date of any meeting as the record date for determining the shareholders entitled to notice of or to vote at any meeting of shareholders or any adjournment thereof, notwithstanding any transfer of any stock in the stock records of the Corporation after any such record date designated as aforesaid.

(a) In the event no record date is fixed: (i) the record date for determining the shareholders entitled to notice of or to vote at a meeting of shareholders shall be at the close of business on the business day next preceding the day on which notice is given or, if notice is waived, at the close of business on the business day next preceding the day on which the meeting is held; (ii) the record date for determining shareholders entitled to give consent to corporate action in writing without a meeting, when no prior action by the Board has been taken, shall be the day on which the first written consent is given, and (iii) the record date for determining shareholders for any other purpose shall be at the close of business on the day on which the Board adopts the resolution relating thereto, or the 60th day prior to the date of such other action, whichever is later.

(b) Only shareholders of record on the close of business on the record date are entitled to notice and to vote, to give written consent or to receive a dividend, distribution or allotment of rights or to exercise the rights, as the case may be, notwithstanding any transfer of any Shares on the books of the Corporation after the record date.

(c) A determination of shareholders of record entitled to notice of or to vote at a meeting of shareholders shall apply to any adjournment of the meeting unless the Board fixes a new record date for the adjourned meeting, but the Board shall fix a new record date if the meeting is adjourned for more than forty-five (45) days from the date set for the original meeting.

Section 6. LIST OF SHAREHOLDERS. The Secretary shall prepare and make a complete list of the shareholders entitled to vote at a shareholders□ meeting, arranged in alphabetical order and showing the address of each shareholder and the number of Shares registered in the name of each shareholder. The list shall be produced and kept at the time and place of the meeting during the whole time thereof, and may be inspected by any shareholder who is present.

Section 7. QUORUM; PARTICIPATION.

(a) The presence, in person or by proxy, of the shareholders representing a majority of the votes entitled to be cast at a meeting shall constitute a quorum. Any one or more shareholders may participate in a meeting by means of telephone, video conference, Skype or similar communication equipment, provided that all persons participating in the meeting can hear each other at the same time. Participation by such means shall constitute presence in person or by proxy at a meeting.

(b) The shareholders present in person or by proxy at a duly organized meeting may continue to do business until adjournment, notwithstanding the withdrawal of enough shareholders to leave less than a quorum. If a quorum is not present or represented at any meeting, the remaining shareholders shall have power to adjourn the meeting without notice until the required Shares shall be represented. At any adjourned meeting at which a quorum shall be present, any business may be transacted which might have been transacted at the meeting as originally called.

Section 8. ADJOURNMENT. Any meeting of the shareholders may be adjourned from time to time whether or not a quorum is present by the vote of a majority of the Shares represented thereat either in person or by proxy. At the adjourned meeting the Corporation may transact any business which might have been transacted at the original meeting.

Section 9. VALIDATION OF ACTIONS TAKEN AT DEFECTIVELY CALLED, NOTICED, OR HELD MEETINGS.

(a) The transactions of any meeting of the shareholders, however called and noticed, and wherever held, are as valid as though had at a meeting duly held after regular call and notice, if a quorum is present either in person or by proxy, and if either before or after the meeting, each of the persons entitled to vote thereat, not present in person or by proxy, signs a written waiver of notice or a consent to the holding of the meeting or an approval of the minutes thereof. Any written waiver of notice shall comply with subdivision (a) of Section 700 of the Connecticut Business Corporations Code. All such waivers, consents and approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

(b) Attendance of a person at a meeting shall constitute a waiver of notice of and presence at such meeting, except (1) when the person objects, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened and (2) that attendance at a meeting is not a waiver of any right to object to the consideration of any matter required by the Connecticut Corporations Code to be included in the notice but not so included, if such objection is expressly made at the meeting.

Section 10. ORGANIZATION. The CEO, or in the absence or disability of the CEO, a director or officer designated by the Board shall preside at all meetings of the shareholders. The Secretary, or in his or her absence or disability one of the Assistant Secretaries, if one has been elected and appointed, shall act as secretary of the meeting. In case none of the officers above designated to act as secretary of the meeting shall be present, a secretary of the meeting shall be chosen by the Board.

Section 11. VOTING.

(a) GENERALLY. At all meetings of the shareholders, each holder of common stock, and present at the meeting in person or by proxy, shall be entitled to one vote for each full Share of the Corporation registered in his or her name. Directors shall be elected by a plurality of the votes of the Shares present in person or represented by proxy at the meeting. Any other action shall be authorized by a majority of the votes cast, except where the law prescribes a different percentage of votes and/or a different exercise of voting power, and except as may be otherwise prescribed by the provisions of the Certificate of Incorporation or these Bylaws. In the election of directors, and for any other action, voting need not be by ballot.

(b) PROXY. Any shareholder of record may be represented at any annual or special meeting of the shareholders by a duly appointed proxy either by instrument in writing subscribed by such shareholder, or by his or her duly authorized attorney or agent, or by any means of electronic communication, such as e-mail or fax, which results in a writing from such shareholder or his or her duly authorized attorney or agent, and delivered to the Secretary or to the inspectors at or before the meeting. Unless the proxy is irrevocable, a proxy shall be revocable at will, provided the shareholder files written notice of the revocation with the Secretary prior to the voting of the proxy.

(c) INSPECTORS. In advance of any meeting of the shareholders, if the Board so directs or if the shareholders consent in writing, one or more inspectors shall be appointed. The inspectors, if any, shall determine the number of Shares outstanding and the voting power of each, the Shares represented at the meeting, the existence of a quorum, the validity and effect of proxies, and shall receive votes or consents, hear and determine all challenges and questions arising in connection with the right to vote, count and tabulate all votes or consents, determine the result, and do such acts as are proper to conduct the election or vote with fairness to all shareholders. At the request of the officer presiding at the meeting, the inspector or inspectors, if any, shall make a report in writing of any challenge, question, or matter determined by such inspector or inspectors. Each inspector, if any, before entering upon the discharge of duties of inspector, shall take and sign an oath faithfully to execute the duties of inspector at such meeting with strict impartiality and according to the best of such inspector's ability.

Section 12. SHAREHOLDER ACTION WITHOUT A MEETING. Any action required or permitted to be taken at a meeting of shareholders may be taken without a meeting if all of the shareholders consent in writing and (except for the annual election of directors) may also be taken without a meeting, without prior notice, and without a vote, by no less than all of the shareholders who would have been entitled to cast the minimum number of votes which would be necessary to authorize any such action at a meeting at which all shareholders thereon were present and voting. Whenever any action is taken pursuant to the foregoing provisions, the written consents of the shareholders consenting thereto or the written report of inspectors appointed to tabulate such consents shall be filed with the minutes of proceedings of shareholders.

ARTICLE IV

BOARD OF DIRECTORS

Section 1. POWERS OF THE BOARD. Subject only to the powers of or reserved to the shareholders by law, the Certificate of Incorporation or these Bylaws, the Board shall have the general direction and control of the activities of the Corporation, and shall have and may exercise all of the powers of the Corporation, including the powers reserved to or of the Corporation with respect to corporations of which the Corporation is a member or stockholder or for which the Corporation otherwise possesses a controlling voting interest.

Section 2. NUMBER OF DIRECTORS. The number of directors on the Board may be fixed or changed from time to time by its shareholders. If not so fixed, the number shall be two (2). The number of directors shall never be less than one (1) and at such times as there is one (1) shareholder of the Corporation, the number of directors of the Corporation may be one (1), as determined and fixed by the shareholder, but shall be two (2) in the absence of such determination.

Section 3. ELECTION; TERM OF OFFICE; VACANCIES. At each annual meeting of the shareholders, the shareholders shall elect the number of directors, as fixed by the Board. Such directors shall hold office until the next annual meeting of the shareholders and until their successors are elected and □ualified, or until any such director sooner dies, resigns, is removed, or becomes dis□ualified to serve as a director, if that should occur prior to the next annual meeting of the shareholders. Any director may be removed from office, with or without cause, by the affirmative vote of the majority of the shareholders present in person or represented by proxy at any meeting of the shareholders at which a □uorum is present. Vacancies of the directors shall be filled by election of the remaining directors, and the individuals so elected shall hold office until the next annual meeting of the shareholders and until their successors are elected and □ualified.

Section 4. MEETINGS.

(a) ANNUAL MEETINGS. There shall be an annual meeting of the Board held on the date of the annual meeting of shareholders, or as soon thereafter as convenient, at the same place as the annual meeting of shareholders unless some other location is designated by the CEO.

(b) REGULAR MEETINGS. Regular meetings of the Board may be held throughout the year, at such time and place as the Board shall designate. If such day falls upon a legal holiday, then said meeting shall be held at the same time on the next day thereafter ensuing which is a full business day.

(c) SPECIAL MEETINGS. The President or CEO may call any special meeting of the Board, and shall do so whenever re□uested in writing by at least a majority of the directors.

(d) MEETINGS BY TELECOMMUNICATIONS. Any one or more members of the Board may participate in a meeting of the Board or any committee thereof by

means of telephone, video conference, Skype or similar communication equipment, provided that all persons participating in the meeting can hear each other at the same time. Participation by such means shall constitute presence in person or by proxy at a meeting.

Section 5. NOTICE. Written notice of all meetings of the Board shall be given to each director before the meeting. Notices required under this Section may be transmitted in person, in writing, or by telephone, internet, e-mail or fax, and shall be effective whether or not actually received, provided they are duly transmitted not less than forty-eight (48) hours in advance of the meeting. Notice may be waived in writing before or after a meeting. Both notice and waiver need not specify the business scheduled for any Board meeting and any business may be transacted at either a regular or special meeting.

Section 6. QUORUM. A majority of the directors then in office shall constitute a quorum for the transaction of business, but the director or directors present, if less than a quorum, may adjourn any meeting from time to time until such quorum shall be present. If there are only two (2) directors then in office, the presence of all directors shall constitute a quorum for the transaction of business. All questions coming before the Board shall be determined and decided by a majority vote of the directors present, unless the vote of a greater number is required by statute, the Certificate of Incorporation or these Bylaws.

Section 7. ADJOURNMENT. A majority of the directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned for more than 24 hours, notice of any adjournment to another time or place shall be given prior to the time of the adjourned meeting to the directors who were not present at the time of the adjournment.

Section 8. ACTION WITHOUT A MEETING. The Board may act without a meeting if, prior or subsequent to such action, each director shall consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as a unanimous vote of such directors.

Section 9. COMPENSATION OF DIRECTORS. The directors shall receive such compensation for their services as directors as may be prescribed by the Board and shall be reimbursed by the Corporation for ordinary and reasonable expense incurred in the performance of their duties.

Section 10. CONFLICTS OF INTEREST. The Corporation's Board shall be subject to and shall adhere to the Corporation's conflicts of interest policy with regard to actual, apparent and potential conflicts of interest and the disclosure of certain interests. All directors shall disclose to the Corporation, in accordance with the Corporation's conflicts of interest policy, all real and apparent conflicts that they discover or have brought to their attention in connection with the Corporation's activities. "Disclosure" as used in these Bylaws shall mean providing promptly to the appropriate persons the existence and nature of the director's conflicting interest, and all facts known to the director respecting the subject matter of the transaction that a director free of such conflicting interest would reasonably believe to be material in deciding whether to proceed with the transaction.

ARTICLE V

COMMITTEES OF THE BOARD OF DIRECTORS

Section 1. POWER OF COMMITTEES. The Board, by resolution adopted by a majority of the directors, may appoint from among its members an executive committee and one or more other committees, each of which shall have at least one (1) member. To the extent provided in such resolution, each such committee, if appointed, shall have and may exercise all the authority of the Board, except those powers which by law, the Certificate of Incorporation, or these Bylaws may not be so delegated. Further, no such committee shall: (a) make, alter or repeal the Bylaws of the Corporation; (b) elect or remove any director; (c) elect or remove any officer; (d) submit to shareholders any action that requires shareholders' approval; or (e) amend or repeal any resolution theretofore adopted by the Board which by its terms is amendable or repealable only by the Board. All committees shall serve at the pleasure of the Board and each committee shall have a chair and a vice chair.

Section 2. CONDUCT OF BUSINESS. Except as otherwise provided by these Bylaws or determined by the Board from time to time, each committee may make rules for the conduct of its business, provided that the business of the committee shall be conducted as nearly as possible in the same manner as is provided by these Bylaws for the Board.

Section 3. MEETINGS OF COMMITTEES. Each committee shall meet on a regular basis at such times and places as it may determine. In addition, each committee shall meet at the call of the Chairman, or respective chair or vice chair of the committee, or the President and CEO in the absence of the respective chair, upon five (5) days' notice. Notice may be given by the person(s) calling the meeting by any means reasonably calculated to reach a committee member.

Section 4. MEETINGS BY TELECOMMUNICATIONS. Members of any committee of the Board may participate in a meeting by means of telephone, video conference, Skype or similar communication equipment, provided that all persons participating in the meeting can hear each other at the same time. Participation by such means shall constitute presence in person or by proxy at a meeting.

Section 5. ROLE OF THE BOARD. The Board, by resolution adopted by a majority of the directors, if a committee or committees are appointed, may: (a) fill any vacancy in any such committee; (b) appoint one or more directors to serve as alternate members of any such committee and to act in the absence or disability of members of any such committee with all the powers of such absent or disabled members; (c) abolish any such committee at its pleasure; (d) remove any director from membership on such committee at any time, with or without cause; and (e) establish as a quorum for any such committee less than a majority of the entire committee, but in no case less than the greater of two (2) persons or one-third (1/3) of the entire committee. The Chairman of the Board may serve on any committee but shall not vote or be counted for purposes of determining a quorum.

ARTICLE VI

AUXILIARY

The Board may, but is not required to, authorize the formation of auxiliary, volunteer, and/or associated organizations to assist in the fulfillment of the purposes of the Corporation.

ARTICLE VII

OFFICERS

Section 1. ENUMERATION OF OFFICERS. The officers of the Corporation shall be a Chief Executive Officer ("CEO"), a President, a Chief Financial Officer ("CFO"), and a Secretary. The officers of the Corporation may include a Chairman of the Board, one or more Vice-Chairmen of the Board, one or more Vice Presidents, one or more Assistant Secretaries, and such other officers as from time to time shall be designated and elected by the Board.

Section 2. ELECTION OF OFFICERS; VACANCIES. All officers of the Corporation shall be elected at the first meeting of the Board after the annual election of directors, and shall hold office for one (1) year and until their respective successors, if any, shall have been duly elected and qualified, or until any such officer sooner dies, resigns, is removed, or becomes disqualified to serve as an officer, if that should occur prior to the next annual election of the officers; provided, however, that all officers, agents, and employees of the Corporation shall be subject to removal (a) at any time, with or without cause, by the affirmative vote of a majority of the directors of the Board, and (b) in accordance with the terms of such officer's, agent's, or employee's applicable employment agreement with the Corporation. Subject to the rights, if any, of the Corporation under any contract of employment, any officer may resign at any time effective upon giving written notice to the CEO, the President, the CFO, the Secretary, and any other officers of the Corporation, unless the notice specifies a later time for the effectiveness of such resignation. At its discretion, the Board may leave unfilled, for such period as it may deem proper, any office except that of CEO, President, CFO, and Secretary. Failure to elect any such officer shall be considered an exercise of this discretionary power.

Section 3. DUTIES OF OFFICERS.

(a) CHIEF EXECUTIVE OFFICER. The CEO shall have general charge and supervision of the operations of the Corporation itself. The CEO shall preside at meetings of the shareholders and directors and exercise all powers and duties commonly incident to the office of CEO. When presiding at such meetings, the CEO shall establish and apply such rules of order as may be advisable in his or her discretion. He shall also perform such other duties as the Board shall designate from time to time.

(b) PRESIDENT. At the request of the CEO or in his or her absence or in the event of his or her inability or refusal to act (and if there be no Chairman of the Board) the President shall perform the duties of the CEO, and when so acting, shall have all of the powers of and be subject to all the restrictions upon the CEO. The President shall perform such other duties and have such other powers as the Board or the CEO from time to time may prescribe.

(c) VICE PRESIDENTS. In the absence or disability of the President, a Vice President shall perform all the duties of the President, and when so acting shall have all the

powers of, and be subject to all the restrictions upon, the President. A Vice President shall have such other powers and perform such other duties as from time to time may be prescribed for him respectively by the Board or as the President may from time to time delegate.

(d) CHIEF FINANCIAL OFFICER. The CFO shall keep, or cause to be kept, the books and records of account of the Corporation. The CFO shall deposit all monies and other valuables in the name and to the credit of the Corporation with such depositories as may be designated from time to time by resolution of the Board. The CFO shall disburse the funds of the Corporation as may be ordered by the Board, shall render to the CEO and the Board, whenever they request it, an account of all of his or her transactions as CFO and of the financial condition of the Corporation, and shall have such other powers and perform such other duties as may be prescribed from time to time by the Board or as the CEO may from time to time delegate.

(e) SECRETARY. The Secretary shall attend all meetings of the shareholders, and of the Board, and shall keep and preserve in books of the Corporation true minutes of the proceedings of all such meetings. The Secretary shall have the custody of all valuable papers and documents of the Corporation, and shall keep the Corporation's stock books, stock ledgers, and stock transfer books, and shall prepare, issue, record, transfer, and cancel certificates of stocks as required by the proper transactions of the Corporation and its shareholders unless these functions be performed by a duly appointed and authorized transfer agent or registrar other than this Corporation. The Secretary shall keep in his or her custody the seal of the Corporation, and shall have authority to affix same to all instruments where its use is required. The Secretary shall give all notices required by statute, by the Certificate of Incorporation, or by the Bylaws. The Secretary shall have all powers and shall perform all duties commonly incident to and vested in the office of Secretary of a corporation. The Secretary shall also perform such other duties as the Board shall designate from time to time.

ARTICLE VIII

CAPITAL STOCK

Section 1. STOCK CERTIFICATES AND OWNERSHIP. Certificates for stock of the Corporation shall be in such form as the Board may from time to time prescribe and as may be required by Connecticut law. Certificates for stock of the Corporation shall be signed by the President or CEO and countersigned by the CFO or the Secretary. The Shares of the Corporation shall be represented by certificates unless the Board shall by resolution provide that some or all of any class or series of stock shall be uncertificated Shares. Any such resolution shall not apply to Shares represented by a certificate until the certificate is surrendered to the Corporation. Notwithstanding the adoption of any resolution providing for uncertificated Shares, every holder of stock represented by certificates and upon request every holder of uncertificated Shares shall be entitled to have a certificate representing the number of Shares registered in certificate form.

Section 2. TRANSFER OF SHARES. Shares of the Corporation shall be transferable on the records of the Corporation only by the holder of record thereof in person or by duly authorized attorney, upon surrender and cancellation for a like number of Shares, in accordance with the provisions of Chapter 8 of the Uniform Commercial Code, as amended from time to time, except as otherwise provided in the Connecticut Business Corporation Act.

Section 3. LOST, STOLEN, OR DESTROYED CERTIFICATES. In the case of lost, destroyed, or wrongfully taken certificates, the Corporation, as a condition precedent to the issuance of a new certificate in place of the original, may require the receipt of a sufficient indemnity bond, if requested by the Board, and satisfaction of other reasonable requirements imposed by the Board to protect the Corporation against any claim that may be made against it, including any expense or liability, on account of the alleged loss, theft or destruction of such certificate or the issuance of such new certificate.

ARTICLE IX

MEDICAL STAFF

Section 1. ORGANIZATION. There shall be a medical staff organization of the Hospital ("Medical Staff") whose membership shall be composed of physicians, dentists, other health care professionals as specified in the Medical Staff bylaws, rules and regulations (the "Medical Staff Bylaws") and appropriately licensed and qualified podiatrists as are privileged to attend patients in such affiliates of the Corporation as are licensed or certified by the State of Connecticut to operate as a health care facility or institution, including without limitation, a hospital, a chronic and convalescent nursing home and an outpatient clinic (a "Health Care Facility" or "Health Care Facilities"). Membership in the Medical Staff shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. The respective rights, powers and responsibilities of the Board and the Medical Staff in connection with the Medical Staff's activities and functions are set forth in the Medical Staff Bylaws, as adopted by both the Board and the Medical Staff. In accordance with the provisions of the Medical Staff Bylaws, the Board shall take final action on Medical Staff recommendations concerning:

(a) Credentialing;

(b) Appointments and reappointments to the Medical Staff;

(c) Delineation of clinical privileges for Medical Staff members and allied health professionals;

(d) Disciplinary and/or corrective action;

(e) All matters relating to professional competency;

(f) A performance improvement program and plan;

(g) Adoption, amendment and, if necessary, repeal of the Medical Staff Bylaws;

(h) Minimum levels of malpractice insurance to be carried by Medical Staff members and allied health professionals; and

(i) Such other matters as may be referred to it by the Medical Staff in accordance with the Medical Staff Bylaws.

Section 2. RESPONSIBILITIES OF THE MEDICAL STAFF. The Medical Staff shall be responsible for investigating and evaluating all matters relating to Medical Staff membership status, credentialing, clinical privileges, performance assessment, and corrective action, and shall require that the Medical Staff adopt and forward to the Board and the Advisory Board specific written recommendations with appropriate supporting documentation.

Section 3. ACTION BY THE BOARD. Final action on all matters relating to Medical Staff membership status, credentialing, clinical privileges, performance assessment, and corrective action shall be taken by the Board after considering the Medical Staff recommendation. In acting on matters of Medical Staff membership status and in granting and defining the scope of clinical privileges to be exercised by each Medical Staff member and allied health professional, the Board shall consider the Medical Staff's recommendations, the supporting information, and criteria set forth in the Medical Staff Bylaws. The terms and conditions of membership status in the Medical Staff, and of the exercise of clinical privileges, shall be as specified in the Medical Staff Bylaws or as more specifically defined in the notice of individual appointment or reappointment. The procedure to be followed by the Medical Staff and Board in acting on matters of membership status, credentialing, clinical privileges, and corrective action shall be as specified in the Medical Staff Bylaws. The Board will review and vote on the Medical Staff's recommendations on a regular basis.

Section 4. MEDICAL STAFF MEMBERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES. The Corporation or a Health Care Facility and a Medical Staff member or group of Medical Staff members, may provide by agreement that Medical Staff membership and clinical privileges are contingent on such agreement. In the event that an agreement has such a provision or there is such an understanding, then Medical Staff membership and clinical privileges shall expire simultaneously with termination of the agreement and shall not be subject to the provisions of the Medical Staff Bylaws concerning hearings, appellate review, or other procedural rights. Notwithstanding the existence of a contract between an individual or group and the Corporation or a Health Care Facility, such individual or group must be appointed and, thereafter, reappointed to the Medical Staff and granted clinical privileges in accordance with the Medical Staff Bylaws. In addition, the contract between the individual or group and the Corporation or Health Care Facility shall control the use of the Health Care Facility's facilities.

Section 5. ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS. The Board shall delegate to the Medical Staff the authority and responsibility to recommend to the Board proposed Medical Staff Bylaws, and amendments thereto, as are appropriate for the proper governance of the Medical Staff. The Board shall act upon such proposed Medical Staff Bylaws, or amendment(s) thereto, recommended by the Medical Staff, at any regular or special meeting at which the matter is duly considered. Provided such proposed Medical Staff Bylaws, or amendment(s) thereto, are approved by the affirmative vote of two-thirds (2/3) of the directors present and voting at such meeting, said proposed Medical Staff Bylaws, or amendment(s) thereto, shall be effective as of the date affirmative action is taken by the Board or at such later date as the Board may specify.

ARTICLE X

VOTING UPON SHARES HELD BY THE CORPORATION

Unless otherwise ordered by the Board, the CEO shall have full power and authority on behalf of the Corporation to attend, to act at, and to vote at any meeting of shareholders of any corporation in which the Corporation may hold shares of stock, and at any such meeting shall possess, and may exercise all rights and powers incident to the ownership of such shares which any owner thereof might possess and exercise if present. The Board, by resolution, from time to time, may confer like powers upon any other person or persons.

ARTICLE XI

FISCAL YEAR

The Board shall have power to fix, and from time to time change, the fiscal year of the Corporation. Unless otherwise fixed by the Board, the calendar year shall be the fiscal year.

ARTICLE XII

SEAL OF THE CORPORATION

The seal of the Corporation shall be in such form as the Board shall prescribe.

ARTICLE XIII

CHECKS AND CONTRACTS

Section 1. CHECKS. All checks, drafts or other orders for the payment of money, and all notes or other evidences of indebtedness issued in the name of the Corporation shall be signed by such officer or officers, or agent or agents of the Corporation, in addition to the officers so authorized by the Bylaws, and in such manner as shall from time to time be determined by resolution of the Board.

Section 2. CONTRACTS. The Board may authorize any officer or officers, or agent or agents of the Corporation, in addition to the officers so authorized by the Bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances.

ARTICLE XIV

RECORDS AND REPORTS

Section 1. MINUTE BOOK. The Corporation shall keep or cause to be kept in written form at its principal executive office or such other place as the Board may order, a minute book which shall contain a record of all actions by its shareholders, Board or committees of the Board, including the time, date and place of each meeting; whether a meeting is regular or special and, if special, how called; the manner of giving notice of each meeting and a copy

thereof; the names of those present at each meeting of the Board or committees thereof; the number of Shares present or represented at each meeting of the shareholders; the proceedings of all meetings; any written waivers of notice, consents to the holding of a meeting or approvals of the minutes thereof; and written consents for action without a meeting.

Section 2. SHARE REGISTER. The Corporation shall keep or cause to be kept at its principal executive office or, if so provided by resolution of the Board, at the Corporation's transfer agent or registrar, a Share register, or a duplicate Share register, which shall contain the names of the shareholders and their addresses, the number and classes of Shares held by each, the number and date of certificates issued for the same and the number and date of cancellation of every certificate surrendered for cancellation.

Section 3. BOOKS AND RECORDS OF ACCOUNT. The Corporation shall keep or cause to be kept at its principal executive office or such other place as the Board may order, adequate and correct books and records of account.

Section 4. BYLAWS. The Corporation shall keep at its principal executive office in the State of Connecticut or, in the absence of such office in the State of Connecticut, at its principal business office in the State of California, the original or a copy of these Bylaws as amended to date.

Section 5. INSPECTION OF RECORDS. The shareholders and directors of the Corporation shall have all of the rights to inspect the books and records of the Corporation that are specified under Connecticut law.

ARTICLE XV

CONFIDENTIALITY

Section 1. GENERALLY. The Corporation and its personnel are in possession of and have access to a broad variety of confidential, sensitive, and proprietary information, the inappropriate release of which could be injurious to individuals, the Corporation's business partners, and the Corporation. Each of the Corporation's directors, officers, employees and agents shall not disclose or use any private, confidential, proprietary or trade secret information relating to the Corporation, except as required in and by the terms of the Certificate of Incorporation, these Bylaws, or by applicable law.

Section 2. PATIENT INFORMATION. All personnel have an obligation to maintain the strict confidentiality of patient information in accordance with all applicable laws and regulations. All personnel shall refrain from revealing or disseminating any personal or confidential information concerning patients except as allowed by law, e.g., for claims processing by insurers or other third-party payers, or for purposes of patient care by the attending physician or other treating or consulting physicians. If questions arise regarding an obligation to maintain the confidentiality of information or the appropriateness of releasing information, employees should seek guidance from the Hospital CEO or the Hospital's Compliance Director.

Section 3. PROPRIETARY INFORMATION. Information, ideas and intellectual property assets of the Corporation are important to organizational success. Information

pertaining to the Corporation's competitive position or business strategies, payment and reimbursement information, and information relating to negotiations with employees or third parties should be protected and shared only with employees having a need to know such information in order to perform their job responsibilities. All personnel should exercise care to ensure that intellectual property rights, including but not limited to rights in patents, trademarks, copyrights, and software, are carefully maintained and managed to preserve and protect their value.

Section 4. PERSONNEL INFORMATION. Salary, benefit, and other personal information relating to personnel of the Corporation shall be treated as strictly confidential. Personnel files, payroll information, disciplinary matters, and similar information shall be maintained in a manner designed to ensure strict confidentiality and in accordance with applicable laws. All personnel should exercise due care to prevent the release or sharing of information beyond those persons who may need such information to fulfill their job functions. If any questions arise concerning the release of employment information, employees should obtain guidance from the Hospital's Compliance Director.

ARTICLE XVI

INDEMNIFICATION

Section 1. To the full extent permitted by the laws of the State of Connecticut, as they exist on the date hereof or as they may hereafter be amended, the Corporation shall indemnify any person (an "Indemnitee") who was or is involved in any manner (including, without limitation, as a party or witness) in any threatened, pending or completed investigation, claim, action, suit or proceeding, whether civil, criminal, administrative, arbitrative, legislative or investigative (including, without limitation, any action, suit or proceeding by or in the right of the Corporation to procure a judgment in its favor) (a "Proceeding"), or who is threatened with being so involved, by reason of the fact that he or she is or was a director or officer of the Corporation, or a present or former member of the Advisory Board or, while serving as a director or officer of the Corporation or as a member of the Advisory Board, is or was at the request of the Corporation also serving as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise (including, without limitation, any employee benefit plan), against all expenses (including attorneys' fees), judgments, fines, penalties, excise taxes and amounts paid in settlement actually and reasonably incurred by the Indemnitee in connection with such Proceeding, provided that, there shall be no indemnification hereunder with respect to any settlement or other non-adjudicated disposition of any threatened or pending Proceeding unless the Corporation has given its prior consent to such settlement or disposition. The right of indemnification created by this Article shall be a contract right enforceable by an Indemnitee against the Corporation, and it shall not be exclusive of any other rights to which an Indemnitee may otherwise be entitled. Notwithstanding any other provision of these Bylaws to the contrary, no person shall be entitled to indemnity if the acts giving rise to the liability constituted misconduct, breach of fiduciary duty, self-dealing, and/or bad faith. Any indemnification under this Section (unless ordered by a court) shall be made by the Corporation only as authorized in the specific case upon a determination that indemnification is proper in the circumstances because he or she has met the applicable standard of conduct set forth above. Such determination shall be made by the Board. The provisions of this Article shall inure to the benefit

of the heirs and legal representatives of an Indemnitee and shall be applicable to Proceedings commenced or continuing after the adoption of this Article, whether arising from acts or omissions occurring before or after such adoption. No amendment, alteration, change, addition or repeal of or to these Bylaws shall deprive any Indemnitee of any rights under this Article with respect to any act or omission of such Indemnitee occurring prior to such amendment, alteration, change, addition or repeal.

Section 2. The Board shall have the power to purchase for the Corporation any insurance necessary or available to pay for any costs, expenses or liabilities incurred by the Corporation on account of the indemnification provisions of this Article.

ARTICLE XVII

LOCAL ADVISORY BOARD

Section 1. PURPOSE. The purpose of the Local Advisory Board of the Corporation (the "Advisory Board") is to serve in an advisory capacity to the Board, except to the extent otherwise expressly provided herein. The roles and responsibilities of the Advisory Board shall be as follows:

(a) serve as a resource for Prospect Medical Holdings, Inc. ("PMH") with respect to PMH's investment of the Commitment Amount, as such term is defined in that certain Asset Purchase Agreement between Greater Waterbury Health Network, Inc. ("GWHN"), on its behalf and on behalf of its wholly owned subsidiaries, and certain indirect subsidiaries of PMH;

(b) consult with the Hospital in the development of the post-Closing strategic capital plan;

(c) serve as a resource for PMH with respect to maintenance and implementation of the Hospital's strategic business plan and in connection with any proposed changes to the strategic business plan;

(d) participate in Medical Staff matters at the Hospital to the extent legally permissible;

(e) oversee and manage the accreditation process for the Hospital;

(f) collaborate with PMH and management of the Hospital on clinical quality matters of the Hospital to share best practices, establish clinical quality goals and measure progress;

(g) maintain and oversee the quality assurance programs at the Hospital; provided, however, that if PMH believes that modifications are needed to the quality assurance programs within two (2) years following the closing of the transaction for the sale of the Hospital by GWHN (the "Closing") due to changed circumstances following the Closing, PMH shall submit a request for such modifications in writing to the Advisory Board, which shall reasonably consider whether to accept such modifications, provided that PMH shall not implement any

modifications to the quality assurance programs without first obtaining the approval of the Advisory Board for such modifications, which approval shall not be unreasonably withheld;

(h) provide support to the Hospital with respect to its physician recruitment efforts; and

(i) provide input to the Hospital and PMH on executive leadership succession at the Hospital.

Section 2. COMPOSITION. The Advisory Board shall be composed of community representatives, physicians on the Hospital's Medical Staff and the CEO of the Corporation. In addition, one representative designated by the Board shall serve as a member of the Advisory Board. For three (3) years following the Closing, the Advisory Board shall include one (1) community representative, who shall serve as a voting member of the Advisory Board with rights and obligations consistent with other voting members; such community representative shall be selected by the Hospital in consultation with the Mayor of Waterbury. The Hospital may nominate one (1) individual from the management of PMH or its affiliates to serve as a member of the Advisory Board.

Section 3. INITIAL MEMBERS. The initial members of the Advisory Board shall include at least five (5) physicians and five (5) other individuals identified by GWHN prior to Closing.

Section 4. ELECTION OF MEMBERS. The Governance Committee of GWHN's board of trustees will nominate, and GWHN's board of trustees will elect prior to Closing, the initial members of the Advisory Board. In appointing the initial members of the Advisory Board, GWHN will give strong consideration to the following factors:

(a) assuring Advisory Board diversity as to age, gender, race and town of residence, with the goal of reflecting the composition of the communities served by the Hospital;

(b) inclusion of individuals involved in the development of GWHN's strategic business plan prior to Closing, in order to maintain the forward momentum for the strategic business plan;

(c) tapping expertise and backgrounds that align with the Advisory Board's roles and responsibilities; and

(d) for community representative members, consideration of those individuals who have demonstrated a commitment to GWHN's mission by serving as GWHN corporators of GWHN prior to Closing.

The Hospital will appoint all new members to the Advisory Board and, in doing so, shall give strong consideration to nominations made by any nominating committee established in accordance with Section 12(a) of this Article.

Section 5. TERM OF OFFICE. Members of the Advisory Board shall serve for a term of three (3) years, subject to consideration of re-election as provided for herein. The initial

members of the Advisory Board shall be divided, as nearly e□ually as may be practical, into three (3) classes with staggered terms such that approximately 1□3 of the members shall serve a term of one (1) year; 1□3 of the members shall serve a term of two (2) years; and 1□3 of the members shall serve a term of three (3) years. Upon expiration of each term, any reelected members shall then be elected to terms of three (3) years, such that the terms of 1□3 of all members will expire each year thereafter. The designation of staggered terms shall not disproportionately impact the members selected by GWHN.

Section 6. REMOVAL OF MEMBERS. All members of the Advisory Board shall be subject to removal at any time, with or without cause, by the affirmative vote of a majority of the Advisory Board or by the Board.

Section 7. MEETINGS OF THE ADVISORY BOARD.

(a) ANNUAL MEETINGS. The Advisory Board shall hold an annual meeting, at such time and place as shall be determined by the Advisory Board, for the purpose of electing officers and for the transaction of such other business as may properly be brought before the meeting.

(b) REGULAR MEETINGS. Regular meetings of the Advisory Board shall be held at least □uarterly, at such time and place as shall be determined by the Advisory Board. Advisory Board members shall be sent notification of the specific time and place and tentative agenda, together with appropriate materials, at least three (3) calendar days prior to the meeting. The Advisory Board shall not be limited to such agenda items during regular meetings.

Section 8. QUORUM. A majority of the members then serving on the Advisory Board shall constitute a □uorum for the transaction of business, but the member(s) present, if less than a □uorum, may adjourn any meeting from time to time until such □uorum shall be present. All □uestions coming before the Advisory Board shall be determined and decided by a majority vote of the members present, unless the vote of a greater number is re□uired by these Bylaws.

Section 9. OFFICERS. The officers of the Advisory Board shall be a chairman, a vice-chairman and a secretary, and may include such other officers as from time to time shall be designated and elected by the Advisory Board.

Section 10. ELECTION AND REMOVAL OF OFFICERS. All officers of the Advisory Board shall be elected at the first meeting of the Advisory Board, and at annual meetings thereafter, and shall hold office for one (l) year and until their respective successors, if any, shall have been duly elected and □ualified, provided, however, that all officers of the Advisory Board shall be subject to removal at any time, with or without cause, by the affirmative vote of a majority of the Advisory Board. At its discretion, the Advisory Board may leave unfilled, for such period as it may deem proper, any office except that of chairman and secretary. Failure to elect any such officer shall be considered an exercise of this discretionary power.

Section 11. DUTIES OF OFFICERS.

(a) CHAIRMAN. The chairman of the Advisory Board shall have general charge and supervision of the operations of the Advisory Board. The chairman shall preside at

meetings of the Advisory Board and shall also perform such other duties as the Advisory Board shall designate from time to time.

(b) VICE-CHAIRMAN. The vice-chairman of the Advisory Board shall have such duties and responsibilities as may be delegated to him/her by the chairman and shall preside at meetings of the Advisory Board in the absence of the chairman.

(c) SECRETARY. The secretary of the Advisory Board shall attend all meetings of the Advisory Board, and shall keep and preserve true minutes of the proceedings of all such meetings. The secretary shall give all notices required by these Bylaws. The secretary shall also perform such other duties as the Advisory Board shall designate from time to time.

Section 12. COMMITTEES OF THE ADVISORY BOARD.

(a) NOMINATING COMMITTEE. The Advisory Board may form a nominating committee for the purpose of identifying, vetting and nominating to the Advisory Board candidates to serve as a member thereof upon election by the Advisory Board, and upon approval of the Board, all in compliance with the terms of these Bylaws.

(b) OTHER COMMITTEES. The Advisory Board may form, on a standing or an ad-hoc basis, such other committees as it deems necessary.

Section 13. AMENDMENT. The Hospital will not amend this Article XVII of the Bylaws without the affirmative vote of two-thirds of the members of the Advisory Board.

ARTICLE XVIII

AMENDING THE BYLAWS; PRECEDENCE

Notwithstanding anything to the contrary set forth in these Bylaws, subject to Article XVII, Section 13, these Bylaws may be altered, amended or repealed by the shareholders at any annual or special meeting of the shareholders (or by the shareholders' unanimous written consent), or by a majority vote of the directors then in office at any annual, regular or special meeting of the Board, so long as notice of the proposed amendment, alteration or repeal be contained in the notice of such Board meeting. Any Bylaws adopted, amended or repealed by the shareholders or Board (as the case may be) may thereafter be adopted, amended or repealed by a majority vote of the directors of the Board then in office or by the shareholders (as the case may be); provided, however, that any resolutions of the shareholders that change or fix the number of directors may only be adopted, amended or repealed by the shareholders.

If there is any inconsistency between these Bylaws (as amended from time to time) and the bylaws, rules or regulations of the Medical Staff, the provisions of these Bylaws shall take precedence in light of the Board's ultimate authority over the Hospital as its governing body.

Greer, Leslie

Subject: FW: Independent Monitor

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, November 04, 2016 3:08 PM
To: Martone, Kim
Cc: Shapiro, Daniel R.; Cass, Barbara; Lazarus, Steven; Jennifer O'Donnell
Subject: Independent Monitor

Hi □im
Prospect is moving along with the selection of the Independent Monitor for the three hospitals, Manchester, Rockville and Waterbury. Colleen Smith is the candidate that has gone the furthest in the vetting process and has been selected to proceed. She was interviewed via phone and in person by hospital representatives, licensure division within DPH also interviewed Colleen and there are phone interviews set up for next week with PMH Corporate. I will send you Colleen Smith□s resume and contact information so OHCA can make arrangements to speak directly with Ms. Smith as well. I also spoke with Dan Shapiro regarding OHCA participation in the process. Please contact me anytime if I can provide additional information or be of further assistance. Thank you

Michele M. Volpe
Bershtein, Volpe & Mc□eon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

Greer, Leslie

From: Martone, Kim
Sent: Monday, November 07, 2016 7:58 AM
To: Roberts, Karen; Cotto, Carmen
Cc: Greer, Leslie
Subject: FW: Colleen Smith Resume oct 14, 2012 V4 Jan.13.2015 v5 5.16 .doc
Attachments: Colleen Smith Resume oct 14, 2012 V4 Jan.13.2015 v5 5.16 .doc; ATT00001.htm

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, November 04, 2016 4:58 PM
To: Martone, Kim
Cc: Shapiro, Daniel R.; Jennifer O'Donnell
Subject: Colleen Smith Resume oct 14, 2012 V4 Jan.13.2015 v5 5.16 .doc

□im
As promised, attached is Colleen Smith□, the proposed independent monitor, resume. Please let me know if I can be of further assistance. Thank you.

41 Laurel Crest Road
Madison, CT 06443
Cell: (203) 671-1348
Email: colleen713.smith@gmail.com

COLLEEN O'BRIEN SMITH, MSN, RN, NEA-BC

EDUCATION

MASTER OF SCIENCE IN NURSING, 1976
University of Connecticut, Storrs, CT

BACHELOR OF SCIENCE IN NURSING, 1973
University of Connecticut, Storrs, CT

EXPERIENCE

2013-present

Nursing Consulting Partners

Healthcare Consultant

Work with clients on their strategic planning efforts, improvements in clinical outcomes, employee engagement and creation of professional practice environments. Conduct Magnet Readiness assessments, including data and document review.

2012

Norwalk Health Systems, Norwalk, Ct.

Interim Chief Operating Officer (March, 2012-August, 2012)

Fulfilled the role of COO during a planned leave of absence. Directed the activities of the following Hospital Departments: Radiology, Laboratory, Emergency Services, EMS, Nursing, and the Cancer Center. As a member of the senior leadership team, participated in strategic planning, service line development and preparation of the operational and capital budget for fiscal year 2013. Served as a member of the Master Facility Planning Project Steering committee.

July-August, 2012

Continued service to this organization in a Quality consultant role, charged with developing structures and processes to assure quality outcomes.

1986 – 2011

MIDDLESEX HEALTH SYSTEMS, Middletown, CT

Chief Nursing Officer (1995 – 2011)

Middlesex Health System is a non-profit healthcare organization serving a population of 250,000 residents. Its service area encompasses the largest geography of any hospital in CT, covering Middletown, Connecticut south to the Shoreline and East of the Connecticut

River. The system includes a 275-bed acute care hospital, Homecare and Hospice Agency, a network of primary care offices, three full service Emergency sites, a diagnostic outpatient center, Ambulatory Surgical Center, and Cancer Center. Middlesex Health System is a four-time winner of the Thompson-Reuters Top 100 Hospitals Award and attained Center of Excellence Certifications in Stroke, CHF, Disease Management, and Bariatric Surgery.

Reporting to the President and CEO, responsible for all Nursing, Emergency, Behavioral Health, Surgical Services, Home Health & Hospice, Case Management, and Pharmacy. Key member of the senior management team responsible for all strategic planning, governance, quality and safety, workforce development and engagement. Responsible for 1,071 FTEs including all Nursing Services, the Departments of Surgery and Anesthesia, Emergency Medicine, Behavioral Health and Hospice.

Managed an operating budget of $650M in gross revenues and $105M in expenses. Responsible for nine Directors and five Physician Chairmen.

Selected Accomplishments:

- Achieved Magnet Designation in 2001 followed by redesignations in 2005, and 2010.
- Reduced RN Vacancy Rate from 12% to 2.5%, sustained over the last three years.
- Reduced Temporary Labor costs from 1.7M to $400,000/year.
- Redesigned several medical surgical units to offer private rooms.
- Developed Peer Review processes at all levels for all areas of responsibility.
- Established a Shared Governance Structure in 2000. Completed a redesign of this structure in 2008.
- Developed an RN Residency Program in 1999. Joined the University Health Consortium in 2008. Annual average new graduate retention rate of 87%.
- Achieved nurse satisfaction rates that surpassed the NDNQI benchmarks since 2002.
- Increased Nurse Certification rates from 34% to 56% in 8 years.
- Developed the Center for Research & Innovation. Secured philanthropic funding for research and evidence based practice projects. Established Clinical Scholars Program to advance evidence based practice.
- Founding Board member of the Middlesex Center for Advanced Orthopedic Surgery. Shared oversight for facility design, build and all operational aspects on this Joint Venture.
- Key member of Service Excellence team. Increased Press Ganey nursing care scores from 82 % to 94 %. All HCHAPS scores now above the state and national benchmark.
- Implemented Cerner Information Systems in Emergency, Inpatient, Pregnancy & Birthing Center, and Surgical Services from 2008 through 2011.
- Developed an outpatient Wound Care Center, the Center for Total Joint Replacement, and a Palliative Care Program.
- Key member of two new building projects: Emergency Department (2008), Critical Care Unit (2011)
- Established an Emergency Crisis Area within the Emergency Department to achieve rapid assessment and safe disposition of acute psychiatric patients.
- Achieved initial designation as a WHO Baby Friendly USA hospital in 2005 and in 2010.
- Established remote telemetry services and central monitoring capability.
- Established formal agreement with University of CT to provide additional nursing research expertise.

- Established a "Dedicated Education Unit" on a Medical unit and established a joint faculty appointment.

Director, Medical/Surgical Nursing (1992 – 1995)

Lead Faculty, Ona M. Wilcox College of Nursing (1986 – 1992)

Faculty for Medical Surgical course in evening program. Overall responsibility for theoretical, clinical, and administrative aspects of course.

Staff Nurse, Connecticut & Florida (1973 – 1986)

Provided nursing care for patients in a variety of clinical settings: Medical/Surgical, ICU, CCU, PACU, & Emergency Department

CERTIFICATIONS

- American Nurses Credentialing Center (ANCC); Magnet Appraiser 2006-2012
- ANCC Certification – Advanced Nursing Administration (NEA-BC) October, 2005 - Present
- Johnson & Johnson – Wharton Fellows Program in Management for Nurse Executives 2005

HEALTHCARE BOARD SERVICE

- Connecticut Hospital Association April, 2015-present
  First Nurse Executive representative appointed to this Board of Ct. CEOs. Responsible for the strategic direction of CHA, oversight of the legislative advocacy platform, and approval of annual operating budget
- Hartford Healthcare Quality and Safety Committee of the HHC Board
  October, 2011-present
  Approval of committee charter, mission, goals and strategic direction for all Quality and Patient Safety initiatives embarked upon by the Hartford Healthcare System. Review of all ongoing Quality and Safety Indicators including installation of an enterprise wide electronic record system

PROFESSIONAL MEMBERSHIPS

- American Nurses Association (ANA)
- American Organization of Nurse Executives (AONE)
- Connecticut Hospital Association (CHA)
  - Past Chair Patient Care Executive Group
  - Committee on Human Resources
    - Subcommittee on Nursing Staffing, Chair
    - Nurse Sensitive Quality Indicators, Chair
  - Hospital Oversight Work Group
- Connecticut Nurses Association (CNA)

- Connecticut Organization of Nurse Executives (ONE-CT)
  - Board Member at Large, 2012-14
  - Past President, Chair, 2010 - Nominations Committee
  - President, 2009
  - President Elect, 2008
  - Board Member, 2007
- Editorial Board of Advances in Nursing
- Founding Member of the Connecticut Nursing Collaborative
- Sigma Theta Tau Nursing Society, 1974 – Present
- VHA CNO Network, Past Co-Chair, Northeast Region

PRESENTATIONS

- "The 5 R's of Redesignation: Relevance, Rewards, Risks, Resources, and Role Redesign", ANCC Magnet Conference, 2014
- "*Building & Sustaining A Magnet Culture – Key Strategies & Lessons Learned*", Leadership Conference – Institute of the Mid South, 2011
- "*How to Blow Up a Council Structure & Begin Again: A Success Story*" – ANCC National Magnet Conference, 2010
- "Documenting the EO's – Six Success Strategies" – ANCC National Magnet Conference, 2010
- "Connecticut Nursing Collaborative – A Plan for Strategic Partners" – Connecticut Nurses Association Annual Convention, 2010
- "*Shared Governance at Middlesex Hospital – Evolving, Empowering, Enculturating"* – Connecticut Hospital Association Nursing Day of Sharing, 2009
- "Department of Nursing – 3rd Generation Magnet – Achieving, Sustaining, Excelling" – Middlesex Hospital Board of Directors Meeting, 2009
- Various Presentations to University of Connecticut, American College of Healthcare Executives, Capitol Alliance Research, Connecticut Hospital Association, and VHA (2008-2002)

PUBLICATIONS

- Leadership Competencies for Clinical Managers; The Renaissance of Transformational Leadership – Chapter 16 "*Achieving Magnet Status: A Story of Leadership*"

AWARDS

- T. Stewart Hamilton, MD, Distinguished Service Award – Connecticut Hospital Association, 2011
- Diamond Jubilee Doris M. Armstrong Award for Outstanding Contributions to Nursing Administration (Connecticut Nurses Association), 2010
- Sixth Annual Distinguished Alumni Award, Eleanor K. Gill Outstanding Award for Clinical Excellence in Nursing, University of Connecticut

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:51 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Independent Monitor
Attachments: Consulting Agrmt Independent Monitor (BVM clean 11.23.16).pdf; Nursing Consulting Partners Work Plan (BVM 11.28.16).pdf

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From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:29 PM
To: Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: Independent Monitor

Attached please find the Consulting Services Agreement and draft Work Plan being proposed for the Independent Monitor. Please let us know if OHCA has signed off on the IM. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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CONSULTING SERVICES AGREEMENT

This Consulting Services Agreement (this "Agreement") is made and entered into to as of the _____ day of November, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") and Nursing Consulting Partners, LLC, through its nurse consultant Colleen Smith, MSN, RN, NEA-BC, herein collectively referred to as ("Consultant").

RECITALS

A. Prospect ECHN has acquired certain healthcare facilities in Connecticut including The Rockville General Hospital Incorporated and Manchester Memorial Hospital (collectively, the "ECHN Facilities").

B. Prospect Waterbury has acquired certain healthcare facilities in Connecticut including The Waterbury Hospital (collectively, the "GWHN Facilities").

C. The State of Connecticut, Department of Public Health, Facility and Licensing Investigations Section ("FLIS") has required pursuant to a Pre-Licensure Consent Order for Prospect Manchester Hospital, Inc., Prospect Rockville Hospital, Inc. and Prospect Waterbury Hospital, Inc., OHCA Final Decision for Greater Waterbury Health Network, Inc., OHCA Final Decision for Eastern Connecticut Health Network, Inc., Quality Assurance Commitment for Greater Waterbury Health Network, Inc., and Quality Assurance Commitment for Eastern Connecticut Health Network, Inc., copies of which are attached as Exhibit A ("Order") that Prospect ECHN and Prospect Waterbury (each a "Licensee" and collectively, the "Licensees") execute a contract with an Independent Monitor ("IM") pre-approved in writing by the Department of Public Health, Office of Healthcare Access ("OHCA") and FLIS pursuant to which the IM will monitor the ECHN Facilities and the GWHN Facilities (each a "Facility" and collectively with any other Facilities subject to the Order, the "Facilities") in compliance with the Order.

D. Consultant desires to perform the services of the IM described in the Order and the Licensees desire to engage Consultant to perform such services, subject to the terms and conditions of this Agreement and in full compliance with the Order.

In consideration of the mutual covenants contained herein, the parties hereto hereby agree as follows:

1. Scope of Services. Consultant will provide the services of the IM as described in the Order and otherwise comply with the Order (collectively, the "Services"). The Licensees shall cooperate with Consultant and provide access to the Facilities, and management and other representatives of the Facilities in order to enable the IM and the Licensees to fully comply with applicable provisions of the Order.

2. Independent Contractor. Consultant and the Licensees acknowledge and agree that Consultant shall provide services as an independent contractor. Consultant and Licensees acknowledge and agree that no employment relationship, partnership, or joint venture shall be formed due to the performance of this Agreement. This Agreement does

not make Consultant the agent or legal representative of Licensees, and Consultant further agrees that no representation will be made by Consultant that would create an apparent agency, employment, partnership, or joint venture relationship. Consultant acknowledges that he is solely responsible for the taxes on his own income and that, as an independent contractor, his payments will be reported on an IRS Form 1099. In addition, Consultant will provide his own insurance, as necessary, and will not be covered under any Licensee's insurance policy or benefits program.

3. Method of Performing Services. Consultant will determine the method, details, and means of performing the services required by this Agreement.

4. Time and Place of Performing Work. Consultant may perform the Services under this Agreement at any suitable time and location Consultant chooses. Such services will be performed outside the usual course of the Licensees' business although Consultant may, from time to time, as Consultant deems necessary, perform services under this Agreement at the Facilities. Consultant shall observe all safety rules, policies and procedures applicable to visitors and vendors at each facility when on site at the Facilities, including requirements for flu and other vaccinations, if requested.

5. Payment. Consultant shall be paid a monthly retainer during the first twelve (12) months of Seventy-Five Hundred Dollars ($7,500) for all Services and Twenty-Five Hundred dollars ($3,500) during the second proceeding twelve (12) months for all Services. Compensation to be paid to IM under this Agreement under no circumstances shall exceed $300,000 in accordance with the Order. Consultant shall be responsible for all taxes attributable to the compensation paid to him under this Agreement. Consultant shall be entitled to no other payment, remuneration, or benefits other than the compensation described in this Agreement. Because Consultant is an independent contractor, the Licensees will not deduct any amounts from Consultant's payments for income tax or other employment-related withholdings.

6. Billing. Consultant shall provide each Licensee with an invoice on a monthly basis providing a general description of the Services performed and number of hours billed for the Services provided to each Licensee. The invoice shall also list any expenses reasonably incurred by Consultant as part of his consulting services, for which he seeks reimbursement, except that Consultant must obtain prior consent before incurring any expense in excess of $500. Each Licensee's payment of Consultant's invoice is due within thirty (30) days of receipt.

7. Term; Termination. This Agreement will begin on the Effective Date and shall continue for a period of two years in accordance with the Order. This Agreement may not be terminated by either party or by mutual consent unless such termination is approved by OHCA and FLIS. The term may be extended at the direction of FLIS for up to (1) additional year, for an overall total of three (3) years, provided that the compensation cap set forth in paragraph 5 shall include any such extended term.

8. Representations. Consultant warrants that all information provided by Consultant to Licensees is true to the best of Consultant's actual knowledge. Consultant further warrants that he is not restricted by, and has no conflict of interest derived from any other agreement and has no other interest or obligation that would interfere with his

performing work as described in this Agreement, and that he shall inform Licensees immediately should such a limitation or conflict arise. Consultant further warrants that the services of Consultant will be provided utilizing reasonable care and skill in accordance with customary industry standards. Consultant represents he/she has expertise in hospital administration and operations, knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals. Consultant represents and warrants that he/she has not been convicted of a criminal offense related to healthcare, debarred, suspended, declared ineligible, or excluded from participating with Medicare, Medicaid or any other plan or program that provides health benefits, whether directly through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any State health care program. This shall be an ongoing representation and warranty during the term of this Agreement. Consultant shall immediately notify Licensees of any change in the status of the representations set forth in this section.

9. Adherence to Health Laws. Consultant acknowledges that Licensees receive federal funds and that Contractor will receive payments under this Agreement that are, in whole or in part, from federal funds. Consultant shall follow and adhere to all applicable state and federal laws, rules, and regulations, including, but not limited to, all Medicare laws, regulations and CMS instructions, including, without limitations, (a) federal criminal law; (b) the False Claims Act (31 USC 3729 et seq.); and (c) the anti-kickback statute (42 USC 1320a-7b(b)); (d) the civil monetary penalties law (42 USC 1320a-7a); (e) the physician self-referral law (42 USC 1395nn).

10. Corporate Compliance. Contractor acknowledges that Licensees maintain Corporate Compliance Plans ("CCPs") that foster prevention, detection and resolution of instances of misconduct. Vendor shall cooperate with Licensees' corporate compliance audits, reviews and investigations that relate to the services provided by Contractor under this Agreement. Contractor agrees to immediately notify Licensees' Compliance Officers of any violation of any applicable law, regulation, third party payor requirements or breach of Licenses' CCPs of which Contractor becomes aware during the term hereof.

11. Insurance. Consultant shall, at his/her sole cost and expense, maintain at all times during the term of this Agreement, general liability ("GL") and errors and omissions ("E&O") insurance covering his/her provision of the Services in minimum amounts of One Million Dollars ($1,000,000) per occurrence, Three Million Dollars ($3,000,000) in the aggregate annually, as well as an umbrella/excess liability insurance policy written on an occurrence basis and in an amount of not less than Three Million Dollars ($3,000,000) in the annual aggregate, excess of the limits of his/her GL and E&O policies (collectively, the "Policies"). Said Policies shall be obtained from an insurer licensed or authorized to do business in Connecticut, with an A.M. Best's Insurance Rating of A- or better. Licensees and their officers, directors, agents, employees, and volunteers (the "Licensee Parties") shall be named as additional insureds to all such Policies, and said Policies shall provide that they are primary to and noncontributory with any and all other insurance maintained by or otherwise afforded to the Licensee Parties. Upon a Licensee's request, Consultant shall provide a current certificate of insurance to Licensee evidencing such coverage and shall require

its insurance carrier to notify Licensee immediately of any actual or intended change, cancellation, modification or non-renewal of such coverage. The obligations set forth herein shall survive the expiration or termination of this Agreement.

12. No Assignment or Subcontracting. Consultant shall not assign or otherwise transfer his rights in this Agreement without the prior written consent of the Licensees and the approval of OHCA and FLIS. Consultant may not subcontract the consulting services to any other consultant without the prior written consent of the Licensees and the approval of OHCA and FLIS.

13. Non-exclusivity. Consultant may represent, perform services for, and contract with as many additional clients, persons, or companies as Consultant, in Consultant's sole discretion, sees fit. Consultant shall not, however, perform services for any other entity where such services would create a conflict of interest with the services performed under this Agreement for Licensees.

14. Non-Solicitation. Consultant agrees that during the term of this Agreement, and for a period of two (2) years after the termination of this Agreement, Consultant shall not solicit, either directly or indirectly, any employee, customer, contractor, vendor, business contact, or consultant to leave Licensees.

15. Trade Secrets, Confidential Information.

(A) For purposes of this Agreement, the term "Confidential Information" means any information relating to Licensees (including any of their subsidiaries, shareholders or other affiliates) disclosed to Consultant, whether orally, in writing, or in any other medium, whether prior to or after the Effective Date of this Agreement, by or on behalf of Licensees, including, without limitation, information regarding Licensees assets, real estate holdings, historical and projected financial information; budgets; services; processes; operations; marketing plans and materials; analyses; strategies; forecasts; names, addresses and any other information regarding Licensees' existing or potential patients, employees, vendors or suppliers; or any information derived, summarized or extracted from any of the foregoing.

(B) Confidential Information shall not include any information which (i) is or becomes available to the public other than as a consequence of a breach of this Agreement; (ii) was available to Consultant on a non-confidential basis prior to its disclosure to Consultant by Licensees; (iii) becomes available to Consultant from a source other than Licensees, provided such source is not actually known by Consultant to be bound by a confidentiality obligation to Licensees; or (iv) is required to be disclosed by Consultant or any of its Representatives (as defined below) under the Order or applicable law or regulation.

(C) Consultant hereby agrees to hold in strict confidence all Confidential Information and agrees not to disclose or otherwise provide or transfer, directly or indirectly, any Confidential Information or anything related to the Confidential Information to third parties, including, but not limited to, Consultant's affiliates, without

the prior written consent of Licensees. Consultant further agrees that he may use the Confidential Information only in connection with the work he will perform for Licensees and to comply with the Order and not for any other purpose or for the benefit of any third party.

(D) Consultant shall not disclose to any third party, except where permitted or required by the Order or by law or where such disclosure is expressly approved by Licensees in writing, any patient or medical record information regarding any of the Licensee's patients, and Consultant shall comply with all federal and state laws and regulations, and all bylaws, rules, regulations, and policies of Licensees, its accrediting agency and the medical staff, regarding the confidentiality of such information. Consultant acknowledges that in receiving or otherwise dealing with any records or information from Licensees about (i) Licensees' patients receiving treatment for alcohol or drug abuse, Consultant is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, as amended from time to time), and/or (ii) Licensees' peer review activities, Consultant is fully bound to maintain the confidentially of such information in accordance with C.G.A.§ 19a-17b(d) . In addition, Consultant shall comply in all respect with HIPAA and the HITECH Act 42 U.S.C. §§300jj et seq.; §§17901 et seq., and shall execute and deliver to Licensees the Business Associate Agreement attached as Exhibit B.

(E) Consultant understands that in the event he fails to comply with paragraph 13 or this paragraph 14, Licensees may suffer irreparable harm, which may not be adequately compensated for by monetary damages alone. Consultant, therefore, agrees that in the event of his breach or threatened breach of paragraph 13 or this paragraph 14, Licensees will be entitled to injunctive and/or other preliminary or equitable relief from a court of law. Consultant understands that this is the sole exception to the binding arbitration of disputes between the parties in accordance with paragraph 20 below.

16. Return of Property and Confidential Information. Consultant agrees that, upon termination of this Agreement, he will promptly return to Licensees all items, documents and materials that are in Consultant's possession or control that were provided to Consultant by Licensees. Consultant further agrees that he will promptly return to Licensees or destroy all written Confidential Information received by Consultant from or on behalf of Licensees, including any and all copies or duplicates of such Confidential Information, and all summaries or extracts thereof in any medium prepared by or on behalf of Consultant. Any destruction of Confidential Information shall be confirmed in writing.

17. Notices. Any required notice under this Agreement shall be deemed made on the date it is personally delivered or, if made by U.S. Mail, Federal Express or similar parcel service, three (3) days after the date it is sent. Notices under this Agreement shall be sent to the following:

If to Consultant:

Nurse Consulting Partners, LLC
6909 S. Park View Court
Franklin, WI 53132

Colleen Smith, MSN, RN, NEA-BC
41 Laurel Crest Road
Madison, CT 06443

If to Licensees:

Prospect ECHN, Inc.
71 Haynes Street
Manchester, CT 06040
Attention: Chief Executive Officer

Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708
Attention: Chief Executive Officer

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

18. Modifications. No Modification or amendment may be made to this Agreement unless it is in writing and signed by Consultant and an authorized officer of Licensees.

19. Entire Agreement. Consultant and Licensees acknowledge and agree that this Agreement which includes Exhibits A and B contains the entire understanding between the parties and that this Agreement replaces and supersedes any other agreement, including any written, oral or implied agreement, regarding the subject matter contained in this Agreement.

20. Arbitration. Any dispute between the parties arising out of this Agreement, including without limitation threshold or jurisdictional issues, such issues of arbitrability on the enforceability of this Agreement, shall be resolved by binding arbitration, pursuant to the commercial dispute rules of the Judicial Arbitration and Mediation Services ("JAMS"). The arbitration shall take place before a single arbitrator. The prevailing party to the arbitration shall be entitled to recover its attorney's fees and costs, including the JAMS arbitration fees. The arbitrator shall be entitled to award any relief or remedy under law, including monetary damages and injunctive relief. Despite this provision, if Consultant breaches paragraph 13 or paragraph 14 of this Agreement, Licensees may seek injunctive relief from a court of law to remedy such a breach.

21. Severability. If any part, clause, or condition of this Agreement is held to

be partially or wholly invalid, unenforceable, or inoperative for any reason whatsoever, such will not affect any other provision or portion hereof, which will continue to be effective as though such invalid, inoperative, or unenforceable part, clause or condition had not been made.

22. Binding Upon Successors. This Agreement will be binding upon and inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns.

23. Governing Law and Venue. All questions concerning this Agreement, its construction, and the rights and liabilities of the parties hereto will be interpreted and enforced in accordance with the laws of the State of Connecticut as applied to contracts which are executed and performed entirely within the state.

Consultant and Licensees represent that they have read and understand the terms of this Agreement, that they have had the opportunity to review this Agreement with the counsel of their choice, and that they are not relying on any advice from the other party regarding this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date.

LICENSEES:

PROSPECT ECHN, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

PROSPECT WATERBURY, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

CONSULTANT:

_____

Name: Colleen Smith, MSN, RN, NEA-BC

Nursing Consulting Partners

By: _____
Name:
Title:

EXHIBIT A

1. Pre-Licensure Consent Order for Prospect Manchester Hospital, Inc.
2. Pre-Licensure Consent Order for Prospect Rockville Hospital, Inc.
3. Pre-Licensure Consent Order for Prospect Waterbury, Inc.
4. OHCA Final Decision for Greater Waterbury Health Network, Inc.
5. OHCA Final Decision for Eastern Connecticut Health Network, Inc.
6. Quality Assurance Commitment for Greater Waterbury Health Network, Inc.
7. Quality Assurance Commitment for Eastern Connecticut Health Network, Inc.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of November ___, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") (together, the "Covered Entities") and Nursing Consulting Partners, LLC ("Business Associate")

R E C I T A L S:

WHEREAS, the Business Associate and Covered Entities have entered into and may enter into one or more agreements (the "Agreement(s)") under which the Business Associate performs or assists the Covered Entities with a function or activity involving the Use or Disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entities and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

WHEREAS, the HIPAA Standards require that the Covered Entities obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information Used or Disclosed by the Business Associate in the course of performing services pursuant to the Agreement(s).

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

1. <u>Definitions</u>

a) HIPAA Rules shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

b) The following terms Used in this business Associate Agreement shall have the same meaning as those terms defined in the HIPAA Standards: Business Associate, Covered Entity, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

c) The Covered Entities and the Business Associate acknowledge and agree that capitalized terms Used, but not otherwise defined, herein are as defined in the HIPAA Standards;

2. Obligations and Activities of Business Associate

a) Business Associate shall not Use or further Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as required by law.

b) Business Associate shall Use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent Use or Disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

c) Business Associate shall immediately report to Covered Entities any Use or Disclosure of Protected Health Information or individually identifiable information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information as required and any Security Incident of which the Business Associate becomes aware. Business Associate shall take any reasonable action necessary or requested by the Covered Entities to mitigate, to the extent practicable, any harmful effect that is known to Business Associate.

d) In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate's notice to Covered Entities of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, or disclosed. Business Associate shall also provide Covered Entities any other available information that the Covered Entities are required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any reasonable action necessary as requested by the Covered Entities to assist Covered Entities in complying with any applicable Breach notification requirements.

e) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor that creates, maintains transmits, or receives Protected Health Information on behalf of Covered Entities agrees to the same restrictions, conditions and requirements that apply through to Business Associate with respect to such information.

f) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:

(i) provide access or make available to Covered Entities Protected Health Information in a Designated Record Set, to Covered Entities or to an Individual, per Covered Entities' direction in order to meet the requirements under 45 C.F.R. § 164.524; and

(ii) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entities direct or agree to

pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual in the time and manner designated by Covered Entity, or take other measures as necessary to satisfy Covered Entities' obligations under 45 C.F.R. 164.526.

g) Business Associate shall maintain and make available to Covered Entity information pertaining to Disclosures of Protected Health Information by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of Disclosures of Protected Health Information made by Business Associate, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.

h) To the extent Business Associate is to carry out one or more of Covered Entities' obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

i) Business Associate shall make internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created, maintained or received by Business Associate on behalf of Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entities' or Business Associate's compliance with the HIPAA Rules.

j) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is Used or Disclosed only as authorized under the HIPAA Rules and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Rules that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Rules. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Rules and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper Use and/or Disclosure of an Individual's information.

k) In the event that Business Associate has knowledge of a Covered Entity's breach of the HIPAA Rules, Business Associate agrees to notify Covered Entity and take reasonable steps to cure such breach.

l) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.

3. <u>Permitted Uses and Disclosures by Business Associate</u>

a) Business Associate may Use or Disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, a Covered Entity as specified in the Agreement(s), provided that such Use or Disclosure would not violate the HIPAA Rules if done by the Covered Entity.

b) Business Associate may Use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c) Business Associate may Disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and will be Used or further Disclosed only as Required by Law or for the purpose for which it was initially Disclosed to the recipient, and the recipient notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d) Except as otherwise permitted by the HIPAA Rules, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, Business Associate agrees to make Uses and Disclosures and requests for protected health information consistent with the Minimum Necessary to accomplish the intended purpose of such Use, Disclosure, or request.

e) Except as otherwise permitted by the HIPAA Rules, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless the Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.

f) If an Individual requests that Business Associate restrict the Disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the Disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

g) Except as otherwise limited in this Business Associate Agreement, Business Associate may Use and Disclose Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

4. Obligations of Covered Entities

a) Covered Entities shall provide Business Associate with the Notice of Privacy Practices that Covered Entities produce in accordance with 45 C.F.R. § 164.520, as well as provide any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.

b) Covered Entities shall provide Business Associate with any changes in, or revocation of, permission by Individual to Use or Disclose Protected Health Information, if such changes affect Business Associate's permitted or required Uses and Disclosures.

c) Covered Entities shall notify Business Associate of any restriction to the Use or Disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522.

d) Covered Entities shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by Covered Entities.

5. Term and Termination

a) Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate at to a Covered Entity when all of the Protected Health Information provided by the Covered Entity to Business Associate, or created, maintained, or received by Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b) Termination for Cause. Upon a Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, the Covered Entity shall provide an opportunity for Business Associate to cure

the breach or end the violation. The Covered Entity shall terminate the Business Associate Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. The Covered Entity may immediately terminate the Business Associate Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in its reasonable discretion.

c) Effect of Termination.

(i) Except as provided in this subsection, upon termination of the Agreement(s) or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entities, or created, maintained or received by Business Associate on behalf of Covered Entities that the Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entities notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(iii) The parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entities and the Business Associate. The parties further agree that the Covered Entities would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entities shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

(iv) Survival. The obligations of Business Associate under this Section shall survive the termination of this Business Associate Agreement.

6. Miscellaneous

a) Interpretation. Any ambiguity in this Business Associate Agreement shall be interpreted in a manner that permits the parties to comply with the HIPAA Rules.

b) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.

c) Amendment. Any party shall have the right to amend this Business Associate Agreement by providing written notice to the other parties in order to bring it into compliance with any law or regulation enacted or promulgated regarding the protection of health information that is any way inconsistent with the terms of this Business Associate Agreement or interferes with the parties' obligations with respect to the protection of health information.

d) Application of State Law. Where any applicable provision of Connecticut State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Rules, the parties shall comply with the applicable provisions of Connecticut State law.

e) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

f) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The parties agree that venue shall lie in Federal and State courts in the State in which the Covered Entities maintain their principal places of business, without regard to conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

g) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the addresses set forth below and shall be considered given upon delivery.

Chief Compliance and Privacy Officer
Prospect ECHN, Inc.

71 Haynes Street
Manchester, CT 06040

Chief Compliance Officer
Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

h) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement(s), Business Associate shall indemnify, hold harmless and defend Covered Entities from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any Use or Disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by Covered Entitles in providing required breach notifications.

IN WITNESS WHEREOF, the parties hereto have executed this Business Associate Agreement as of the Effective Date.

BUSINESS ASSOCIATE
NURSING CONSULTING PARTNERS, LLC

By:_____
Printed Name:
Title:
Date:

COVERED ENTITY
PROSPECT ECHN, INC.

By:_____
Printed Name:
Title:
Date:

COVERED ENTITY
PROSPECT WATERBURY, INC.

By:_____
Printed Name:
Title:
Date:

Nursing Consulting Partners, LLC

PROSPECT ECHN, INC. WOR PLAN

Draft 11 28 16

INDEPENDENT MONITORING PROCEDURES (per Docket Number 15-32016-486)

OHCA Condition	IM Action
CON Condition 4: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement ECHN's 2016 Community Health Needs Assessment ("CHNA") and for conducting the New Hospitals' next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following: (i) the data that will be collected and analy ed to systematically assess health status Indicators of the Service Area; (ii) the identity of key community stakeholders and health organi ations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation; (iii) the ualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined; (iv) the fre uency with which the Study will be repeated; (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the community; and (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospitals.	IM will obtain a copy of the Plan, verify timely submission, verify that it incorporated the re uired elements.
CON Condition 5: Within three (3) years following the Closing Date, PMH shall participate with New ECHN and the New Hospitals, and the key community stakeholders and health organi ations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utili e Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at http: www.ct.gov dph lib dph state_health_planning sha-	IM will obtain a copy of the Study, verify timely submission, verify that it incorporated the re uired elements and was published on the website.

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ship hct2020 hct2020_state_hlth_impv_032514.pdf) as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6 18 initiative (available at http: www.cdc.gov sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on the website pages of New MMH and New RGH. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement ECHN's current CHNA for MMH and RGH. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*	
CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospitals for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will obtain a copy of the Plan and verify it incorporated the re uired elements.
CON Condition 7: Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New MMH or New RGH specific to those services that existed at each of the Hospitals as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospitals. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will verify proper notification to OHCA within 10 days of any plan to reallocate inpatient beds and relocation of outpatient services. IM will assure timely publication on New Hospitals website within 10 days of decision to reallocate or relocate services.
CON Condition 8: Within one hundred and eighty (180) days	IM will obtain the Plan, read the plan and verify that

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

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following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the $75 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill the Capital Commitment. The reports shall be signed by PMH ECHN's Chief Financial Officer. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 38-45*	expenditures/investments made are in accordance with the Plan. IM will confirm timely submissions of all required reports.
<u>CON Condition 9:</u> For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for New ECHN, New MMH and New RGH, respectively: a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA	IM will review the PMH filings regarding cost savings achieved in accordance with a. 1-2 and b. of Condition 9.

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Hospital Reporting System (□HRS□) Report 175 or successor report. The semi-annual submission shall also contain narratives describing: 1. the major cost savings achieved for each expense category for the semi-annual period; and 2. the effect of these cost savings on the clinical □uality of care. b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA□s□HRS Reports 100□150, 300□350 or successor reports. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The re□uired information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*	
<u>CON Condition 10:</u> For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New ECHN, New MMH and New RGH, respectively. The re□uired information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements□indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Liquidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to e□uity, long-term debt to capitali□ation, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and e□uity financing ratio; and (iv) **Additional Statistics** to include income from operations, revenue over (under) expense, cash from operation, cash and cash e□uivalents, net working capital, free cash flow (and the elements used in the calculation), unrestricted net assets□retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	IM will obtain the financial measurement report and read to confirm that the re□uired elements are addressed in the report; IM will confirm the timely submission of each report.

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CON Condition 11: PMH shall ensure that New MMH and New RGH maintain and adhere to ECHN's current policies regarding charity care, indigent care and community volunteer services at New MMH and New RGH after the Closing Date all as consistent with state and federal law or adopt other policies that are at least as generous and benevolent to the community as ECHN's current policies. These policies shall be posted on the website pages of the New MMH and New RGH, respectively, and as additionally re□uired by applicable law. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain copies of the relevant financial assistance policies, read and confirm that as adopted financial assistance policies (or policies at least as generous as these policies) using management approval of the policies as evidence. After verifying that this step has been properly completed, IM will confirm that these policies are properly posted on website
CON Condition 12: For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of New MMH and New RGH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website pages of the New Hospitals simultaneously with their submission to OHCA. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	After obtaining original policies on charity care, indigent care, and community volunteer services, IM will read and assess these policies on an annual basis for changes. When changes are made to these policies, IM will confirm OHCA is notified (as re□uired) and revised policies are posted to the website.
CON Condition 13: PMH shall maintain community benefit programs and community building activities for New MMH and New RGH for three (3) years after the Closing Date consistent with the MMH and RGH most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as ECHN's current programs, and PMH shall apply a 1□ increase per year for the next three (3) years toward community building activities in terms of dollars spent. In determining the New MMH and New RGH participation in and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition to ensure continued access to health care services to the patient population.	IM will obtain most recent Schedule H of IRS Form 990 to act as a baseline. IM will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase re□uirement has been met. IM will also obtain the report□summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. IM will confirm that these documents are filed in a timely manner and posted to the website.

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Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59	
CON Condition 14: New MMH and New RGH agree to comply with the following general community benefit standards for at least the first three years. (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusions of other □ualified doctors; (c) the New Hospitals shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24□7 emergency departments and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); Tr., Testimony of Tom Reardon, President. PMH East on 5/3/16, pp. 103-04*	IM will verify the New Hospitals' compliance with community benefit standards a through d as stated in Condition 14.
CON Condition 15: New MMH and New RGH shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations. Specifically, New MMH and New RGH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, New MMH and New RGH shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, New MMH and New RGH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services □Office of Minority Health. For three (3) years following the Closing Date, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition so as to ensure continued access to health care services to the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain and review interpreter services policies and contracts as applicable. Additionally, IM will obtain a cultural competency plan, training, as well as related policies. IM will also obtain report and supporting documents and confirm the timely filing of these materials
CON Condition 16: Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who	IM and PMH will execute a Consulting Services Agreement

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has experience in hospital administration and regulation, including maintaining quality control in a High Reliability Organization ("HRO"). The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing Date, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to New Hospitals and their applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	by the required date. A draft of this Agreement has been provided to OHCA.
CON Condition 17: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of New Hospitals on no less than a semi-annual basis to assess PMH's modified Quality Assurance Performance Improvement ("QAPI") program, each facility's efforts to remain an HRO, and compliance with the Quality Commitment Letter. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	IM will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration Leadership. IM will verify compliance with the Quality Assurance commitment Letter. IM will provide a written report to OHCA, and FLIS that summaries the activities from the prior six month period along with any recommendations or observations
CON Condition 18: If, at any time within three (3) years following the Closing Date, the New Hospitals' Local Board agrees with PMH to change any of the Seller Quality Programs described in the Quality Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and the Health Systems Branch in writing within thirty (30) days of any such change going into	IM will verify that PMH notifies OHCA and the Health Systems Branch in writing within 30 days of any change in the Seller Quality Programs with the exceptions i through iii as stated in condition 18.

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effect. If the Independent Monitor disagrees with the change, OHCA may re□uire that a re□uest for modification be submitted and approved as re□uired by C.G.S. □4-18la to make the change. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*	
CON Condition 19: For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals' activities and afforded an opportunity to ask □uestions and make comments. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will assure that Joint Board Meetings occur twice annually followed by public meetings as re□uired in Condition 19.
CON Condition 20: For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will verify the New MMH and New RGH include 2 community representatives that are voting members of the local boards.
CON Condition 21: PMH, New ECHN, New MMH and New RGH shall abide by all re□uirements of licensure that may be imposed by DPH's Health Systems Branch (HSB) in any Pre-Licensing Consent Order or similar agreement that HSB may enter with these parties. OHCA is imposing this condition to ensure that □uality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 30-37*	IM will verify that all re□uirements of licensure are met.

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Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:51 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Independent Monitor

From: Martone, Kim
Sent: Monday, November 28, 2016 2:34 PM
To: 'Jennifer O'Donnell'; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: RE: Independent Monitor

Thank You Jennifer. We will review the documents and get back to you as soon as possible.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:29 PM
To: Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: Independent Monitor

Attached please find the Consulting Services Agreement and draft Work Plan being proposed for the Independent Monitor. Please let us know if OHCA has signed off on the IM. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:51 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Independent Monitor

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:45 PM
To: Roberts, Karen
Cc: Martone, Kim; Cotto, Carmen; Michele Volpe
Subject: RE: Independent Monitor

Yes, the IM is working on the Waterbury work plan and it will be similar to ECHN. Also, please cc Michele Volpe (mmv@bvmlaw.com) on all correspondence as I'm leaving early today. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Monday, November 28, 2016 2:40 PM
To: Jennifer O'Donnell <jlo@bvmlaw.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Independent Monitor

Hi Jennifer – this draft work plan is specific to the ECHN CON Order. Does BVM and the proposed IM anticipate that the work plan for the Waterbury CON order will be very similar, if not identical, to this one? Thanks. Karen Roberts

Karen Roberts

Greer, Leslie

Subject: FW: Independent Monitor

From: Martone, Kim
Sent: Monday, November 28, 2016 3:43 PM
To: 'Jennifer O'Donnell'; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: RE: Independent Monitor

Jennifer, we have reviewed all documents submitted and approve Colleen Smith as the Independent Monitor for the acquisitions of Prospect Medical Holdings in Connecticut. The understanding is that this office and Colleen will continue to refine and revise the draft work plan until we agree upon its finalization. We also look forward to working directly with the hospital representatives to ensure that responsibilities and obligations of the IM and hospitals are clear to everyone involved in this process.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:29 PM
To: Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: Independent Monitor

Attached please find the Consulting Services Agreement and draft Work Plan being proposed for the Independent Monitor. Please let us know if OHCA has signed off on the IM. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:59 PM
To: Greer, Leslie
Subject: FW: Schedule conference call

From: Cotto, Carmen
Sent: Wednesday, November 09, 2016 5:07 PM
To: Michele Volpe (mmv@bvmlaw.com)
Cc: Jennifer O'Donnell (jlo@bvmlaw.com); Roberts, Karen; Martone, Kim; Olejarz, Barbara
Subject: Schedule conference call

Hi Michele,

Thank you for providing OHCA with a copy of Ms. Smith's resume. In addition to the resume, please provide us with a copy of the Independent Monitor's work plan and engagement letter between Ms. Smith's and the Applicants.

Our office would like to schedule a conference call with you soon, possible next week, to discuss Ms. Smith's qualifications, work plan and engagement letter.

Please contact Ms. Barbara Olejarz at (860)418-7005 or via email at Barbabra.Olejarz@ct.gov to schedule the call.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Martone, Kim
Sent: Monday, November 07, 2016 7:58 AM
To: Roberts, Karen; Cotto, Carmen

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:59 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Schedule conference call
Attachments: CSmith Consulting Services Agmt.pdf

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Thursday, November 17, 2016 9:58 AM
To: Cotto, Carmen; Michele Volpe
Cc: Roberts, Karen; Martone, Kim; Olejarz, Barbara
Subject: RE: Schedule conference call

Ms. Cotto: Attached please find a copy of the proposed contract with Ms. Smith. We are happy to schedule a conference call to discuss Ms. Smith's qualifications, work plan and engagement letter. Please let us know when would be a convenient time for OHCA. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, November 9, 2016 5:07 PM
To: Michele Volpe <mmv@bvmlaw.com>
Cc: Jennifer O'Donnell <jlo@bvmlaw.com>; Roberts, Karen <Karen.Roberts@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Olejarz, Barbara <Barbara.Olejarz@ct.gov>
Subject: Schedule conference call

Hi Michele,

CONSULTING SERVICES AGREEMENT

This Consulting Services Agreement (this "Agreement") is made and entered into to as of the _____ day of November, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") and Colleen Smith, MSN, RN, NEA-BC ("Consultant").

RECITALS

A. Prospect ECHN has acquired certain healthcare facilities in Connecticut including The Rockville General Hospital Incorporated and Manchester Memorial Hospital (collectively, the "ECHN Facilities").

B. Prospect Waterbury has acquired certain healthcare facilities in Connecticut including The Waterbury Hospital (collectively, the "GWHN Facilities").

C. The State of Connecticut, Department of Public Health, Facility and Licensing Investigations Section ("FLIS") has required pursuant to a Pre-Licensure Consent Order, copies of which are attached as Exhibit A ("Order") that Prospect ECHN and Prospect Waterbury (each a "Licensee" and collectively, the "Licensees") execute a contract with an Independent Monitor ("IM") pre-approved in writing by the Department of Public Health, Office of Healthcare Access ("OHCA") and FLIS pursuant to which the IM will monitor the ECHN Facilities and the GWHN Facilities (each a "Facility" and collectively with any other Facilities subject to the Order, the "Facilities") in compliance with the Order.

D. Consultant desires to perform the services of the IM described in the Order and the Licensees desire to engage Consultant to perform such services, subject to the terms and conditions of this Agreement and in full compliance with the Order.

In consideration of the mutual covenants contained herein, the parties hereto hereby agree as follows:

1. Scope of Services. Consultant will provide the services of the IM as described in the Order and otherwise comply with the Order (collectively, the "Services"). The Licensees shall cooperate with Consultant and provide access to the Facilities, and management and other representatives of the Facilities in order to enable the IM and the Licensees to fully comply with applicable provisions of the Order.

2. Independent Contractor. Consultant and the Licensees acknowledge and agree that Consultant shall provide services as an independent contractor. Consultant and Licensees acknowledge and agree that no employment relationship, partnership, or joint venture shall be formed due to the performance of this Agreement. This Agreement does not make Consultant the agent or legal representative of Licensees, and Consultant further agrees that no representation will be made by Consultant that would create an apparent agency, employment, partnership, or joint venture relationship. Consultant acknowledges that he is solely responsible for the taxes on his own income and that, as an independent contractor, his payments will be reported on an IRS Form 1099. In addition,

Consultant will provide his own insurance, as necessary, and will not be covered under any Licensee's insurance policy or benefits program.

3. Method of Performing Services. Consultant will determine the method, details, and means of performing the services required by this Agreement.

4. Time and Place of Performing Work. Consultant may perform the Services under this Agreement at any suitable time and location Consultant chooses. Such services will be performed outside the usual course of the Licensees' business although Consultant may, from time to time, as Consultant deems necessary, perform services under this Agreement at the Facilities. Consultant shall observe all safety rules, policies and procedures applicable to visitors and vendors at each facility when on site at the Facilities, including requirements for flu and other vaccinations, if requested.

5. Payment. Consultant shall be paid an hourly rate of $_____ per hour for all Services. Compensation to be paid to IM under this Agreement under no circumstances shall exceed $300,000 in accordance with the Order. Consultant shall be responsible for all taxes attributable to the compensation paid to him under this Agreement. Consultant shall be entitled to no other payment, remuneration, or benefits other than the compensation described in this Agreement. Because Consultant is an independent contractor, the Licensees will not deduct any amounts from Consultant's payments for income tax or other employment-related withholdings.

6. Billing. Consultant shall provide each Licensee with an invoice on a monthly basis providing a general description of the Services performed and number of hours billed for the Services provided to each Licensee. The invoice shall also list any expenses reasonably incurred by Consultant as part of his consulting services, for which he seeks reimbursement, except that Consultant must obtain prior consent before incurring any expense in excess of $250. Each Licensee's payment of Consultant's invoice is due within thirty (30) days of receipt.

7. Term; Termination. This Agreement will begin on the Effective Date and shall continue for a period of two years in accordance with the Order. This Agreement may not be terminated by either party or by mutual consent unless such termination is approved by OHCA and FLIS. The term may be extended at the direction of FLIS for up to (1) additional year, for an overall total of three (3) years, provided that the compensation cap set forth in paragraph 5 shall include any such extended term.

8. Representations. Consultant warrants that all information provided by Consultant to Licensees is true to the best of Consultant's actual knowledge. Consultant further warrants that he is not restricted by, and has no conflict of interest derived from any other agreement and has no other interest or obligation that would interfere with his performing work as described in this Agreement, and that he shall inform Licensees immediately should such a limitation or conflict arise. Consultant further warrants that the services of Consultant will be provided utilizing reasonable care and skill in accordance with customary industry standards. Consultant represents he/she has expertise in hospital administration and operations, knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws

and regulations applicable to general/acute care hospitals. Consultant represents and warrants that he/she has not been convicted of a criminal offense related to healthcare, debarred, suspended, declared ineligible, or excluded from participating with Medicare, Medicaid or any other plan or program that provides health benefits, whether directly through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any State health care program. This shall be an ongoing representation and warranty during the term of this Agreement. Consultant shall immediately notify Licensees of any change in the status of the representations set forth in this section.

9. Adherence to Health Laws. Consultant acknowledges that Licensees receive federal funds and that Contractor will receive payments under this Agreement that are, in whole or in part, from federal funds. Consultant shall follow and adhere to all applicable state and federal laws, rules, and regulations, including, but not limited to, all Medicare laws, regulations and CMS instructions, including, without limitations, (a) federal criminal law; (b) the False Claims Act (31 USC 3729 et seq.); and (c) the anti-kickback statute (42 USC 1320a-7b(b)); (d) the civil monetary penalties law (42 USC 1320a-7a); (e) the physician self-referral law (42 USC 1395nn).

10. Corporate Compliance. Contractor acknowledges that Licensees maintain Corporate Compliance Plans ("CCPs") that foster prevention, detection and resolution of instances of misconduct. Vendor shall cooperate with Licensees' corporate compliance audits, reviews and investigations that relate to the services provided by Contractor under this Agreement. Contractor agrees to immediately notify Licensees' Compliance Officers of any violation of any applicable law, regulation, third party payor requirements or breach of Licenses' CCPs of which Contractor becomes aware during the term hereof.

11. Insurance. Consultant shall, at his/her sole cost and expense, maintain at all times during the term of this Agreement, general liability ("GL") and errors and omissions ("E&O") insurance covering his/her provision of the Services in minimum amounts of One Million Dollars ($1,000,000) per occurrence, Three Million Dollars ($3,000,000) in the aggregate annually, as well as an umbrella/excess liability insurance policy written on an occurrence basis and in an amount of not less than Three Million Dollars ($3,000,000) in the annual aggregate, excess of the limits of his/her GL and E&O policies (collectively, the "Policies"). Said Policies shall be obtained from an insurer licensed or authorized to do business in Connecticut, with an A.M. Best's Insurance Rating of A- or better. Licensees and their officers, directors, agents, employees, and volunteers (the "Licensee Parties") shall be named as additional insureds to all such Policies, and said Policies shall provide that they are primary to and noncontributory with any and all other insurance maintained by or otherwise afforded to the Licensee Parties. Upon a Licensee's request, Consultant shall provide a current certificate of insurance to Licensee evidencing such coverage and shall require its insurance carrier to notify Licensee immediately of any actual or intended change, cancellation, modification or non-renewal of such coverage. The obligations set forth herein shall survive the expiration or termination of this Agreement.

12. No Assignment or Subcontracting. Consultant shall not assign or otherwise transfer his rights in this Agreement without the prior written consent of the Licensees and the approval of OHCA and FLIS. Consultant may not subcontract the consulting services to any other consultant without the prior written consent of the Licensees and the approval of OHCA and FLIS.

13. Non-exclusivity. Consultant may represent, perform services for, and contract with as many additional clients, persons, or companies as Consultant, in Consultant's sole discretion, sees fit. Consultant shall not, however, perform services for any other entity where such services would create a conflict of interest with the services performed under this Agreement for Licensees.

14. Non-Solicitation. Consultant agrees that during the term of this Agreement, and for a period of two (2) years after the termination of this Agreement, Consultant shall not solicit, either directly or indirectly, any employee, customer, contractor, vendor, business contact, or consultant to leave Licensees.

15. Trade Secrets, Confidential Information.

(A) For purposes of this Agreement, the term "Confidential Information" means any information relating to Licensees (including any of their subsidiaries, shareholders or other affiliates) disclosed to Consultant, whether orally, in writing, or in any other medium, whether prior to or after the Effective Date of this Agreement, by or on behalf of Licensees, including, without limitation, information regarding Licensees assets, real estate holdings, historical and projected financial information; budgets; services; processes; operations; marketing plans and materials; analyses; strategies; forecasts; names, addresses and any other information regarding Licensees' existing or potential patients, employees, vendors or suppliers; or any information derived, summarized or extracted from any of the foregoing.

(B) Confidential Information shall not include any information which (i) is or becomes available to the public other than as a consequence of a breach of this Agreement; (ii) was available to Consultant on a non-confidential basis prior to its disclosure to Consultant by Licensees; (iii) becomes available to Consultant from a source other than Licensees, provided such source is not actually known by Consultant to be bound by a confidentiality obligation to Licensees; or (iv) is required to be disclosed by Consultant or any of its Representatives (as defined below) under the Order or applicable law or regulation.

(C) Consultant hereby agrees to hold in strict confidence all Confidential Information and agrees not to disclose or otherwise provide or transfer, directly or indirectly, any Confidential Information or anything related to the Confidential Information to third parties, including, but not limited to, Consultant's affiliates, without the prior written consent of Licensees. Consultant further agrees that he may use the Confidential Information only in connection with the work he will perform for Licensees and to comply with the Order and not for any other purpose or for the benefit of any third party.

(D) Consultant shall not disclose to any third party, except where permitted or required by the Order or by law or where such disclosure is expressly approved by Licensees in writing, any patient or medical record information regarding any of the Licensee's patients, and Consultant shall comply with all federal and state laws and regulations, and all bylaws, rules, regulations, and policies of Licensees, its accrediting agency and the medical staff, regarding the confidentiality of such information. Consultant acknowledges that in receiving or otherwise dealing with any records or information from Licensees about (i) Licensees' patients receiving treatment for alcohol or drug abuse, Consultant is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, as amended from time to time), and/or (ii) Licensees' peer review activities, Consultant is fully bound to maintain the confidentially of such information in accordance with C.G.A.§ 19a-17b(d) . In addition, Consultant shall comply in all respect with HIPAA and the HITECH Act 42 U.S.C. §§300jj et seq.; §§17901 et seq., and shall execute and deliver to Licensees the Business Associate Agreement attached as Exhibit B.

(E) Consultant understands that in the event he fails to comply with paragraph 13 or this paragraph 14, Licensees may suffer irreparable harm, which may not be adequately compensated for by monetary damages alone. Consultant, therefore, agrees that in the event of his breach or threatened breach of paragraph 13 or this paragraph 14, Licensees will be entitled to injunctive and/or other preliminary or equitable relief from a court of law. Consultant understands that this is the sole exception to the binding arbitration of disputes between the parties in accordance with paragraph 20 below.

16. Return of Property and Confidential Information. Consultant agrees that, upon termination of this Agreement, he will promptly return to Licensees all items, documents and materials that are in Consultant's possession or control that were provided to Consultant by Licensees. Consultant further agrees that he will promptly return to Licensees or destroy all written Confidential Information received by Consultant from or on behalf of Licensees, including any and all copies or duplicates of such Confidential Information, and all summaries or extracts thereof in any medium prepared by or on behalf of Consultant. Any destruction of Confidential Information shall be confirmed in writing.

17. Notices. Any required notice under this Agreement shall be deemed made on the date it is personally delivered or, if made by U.S. Mail, Federal Express or similar parcel service, three (3) days after the date it is sent. Notices under this Agreement shall be sent to the following:

If to Consultant:
Colleen Smith, MSN, RN, NEA-BC
41 Laurel Crest Road
Madison, CT 06443

If to Licensees:

Prospect ECHN, Inc.
71 Haynes Street
Manchester, CT 06040
Attention: Chief Executive Officer

Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708
Attention: Chief Executive Officer

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

18. Modifications. No Modification or amendment may be made to this Agreement unless it is in writing and signed by Consultant and an authorized officer of Licensees.

19. Entire Agreement. Consultant and Licensees acknowledge and agree that this Agreement which includes Exhibits A and B contains the entire understanding between the parties and that this Agreement replaces and supersedes any other agreement, including any written, oral or implied agreement, regarding the subject matter contained in this Agreement.

20. Arbitration. Any dispute between the parties arising out of this Agreement, including without limitation threshold or jurisdictional issues, such issues of arbitrability on the enforceability of this Agreement, shall be resolved by binding arbitration, pursuant to the commercial dispute rules of the Judicial Arbitration and Mediation Services ("JAMS"). The arbitration shall take place before a single arbitrator. The prevailing party to the arbitration shall be entitled to recover its attorney's fees and costs, including the JAMS arbitration fees. The arbitrator shall be entitled to award any relief or remedy under law, including monetary damages and injunctive relief. Despite this provision, if Consultant breaches paragraph 13 or paragraph 14 of this Agreement, Licensees may seek injunctive relief from a court of law to remedy such a breach.

21. Severability. If any part, clause, or condition of this Agreement is held to be partially or wholly invalid, unenforceable, or inoperative for any reason whatsoever, such will not affect any other provision or portion hereof, which will continue to be effective as though such invalid, inoperative, or unenforceable part, clause or condition had not been made.

22. Binding Upon Successors. This Agreement will be binding upon and inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns.

23. Governing Law and Venue. All questions concerning this Agreement, its construction, and the rights and liabilities of the parties hereto will be interpreted and enforced in accordance with the laws of the State of Connecticut as applied to contracts which are executed and performed entirely within the state.

Consultant and Licensees represent that they have read and understand the terms of this Agreement, that they have had the opportunity to review this Agreement with the counsel of their choice, and that they are not relying on any advice from the other party regarding this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date.

LICENSEES:

PROSPECT ECHN, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

PROSPECT WATERBURY, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

CONSULTANT:

_____

Name: Colleen Smith, MSN, RN, NEA-BC

EXHIBIT A

COPY OF ORDER

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

In Re: Prospect Manchester Hospital, Inc.
d/b/a The Manchester Memorial Hospital
71 Haynes Street
Manchester, CT 06040

Intended Licensee: Prospect Manchester Hospital, Inc.
d/b/a Manchester Memorial Hospital
Referred to herein as the "Intended Licensee"

PRE-LICENSURE CONSENT ORDER

WHEREAS, Prospect Medical Holdings, Inc. ("Prospect") has obtained certain regulatory approvals to acquire, through one or more subsidiaries, various licensed facilities or operations currently affiliated with Eastern Connecticut Health Network, Inc., including: Manchester Memorial Hospital and Rockville General Hospital ("ECHN Facilities"); and,

WHEREAS, Prospect is seeking to also acquire, through one or more subsidiaries, certain licensed facilities or operations currently affiliated with the Greater Waterbury Health Network, Inc., including the Waterbury Hospital ("GWHN Facilities" and together with the ECHN Facilities referred to as the "Prospect CT Group"); and,

WHEREAS, the Intended Licensee, a subsidiary of Prospect is seeking an initial license to operate a general hospital as defined in Conn. Gen. Stat. § 19a-490(b); and,

WHEREAS, upon the execution of this Pre-Licensure Consent Order ("Order") and after meeting all statutory and regulatory requirements, the Intended Licensee shall be issued a license to operate a General Hospital currently known as Manchester Memorial Hospital ("Facility") by the Connecticut Department of Public Health ("Department").

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department ("FLIS") acting herein and through Barbara Cass, Section Chief, and the Intended Licensee and Prospect hereby stipulate and agree as follows:

1. The Order issued by the Department of Public Health, Office of Health Care Access ("OHCA") dated June 10, 2016 ("OHCA Order") shall be incorporated and made part of this Order.
2. This Order shall remain in effect for three (3) years from the effective date of this Order. The effective date of the Order is October 1, 2016. The issuance of the License shall occur when the Department receives proof, to its satisfaction, that the closing regarding the ECHN Facilities will occur within forty-eight hours of the issuance of the license provided all legal requirements for licensure have been met.
3. During the term of this Order, should the Intended Licensee implement any new patient care services, it shall do so in accordance with Connecticut General Statutes sections 19a-638 through 19a-639b. In addition, for one year after the effective date of this Order, the Intended Licensee and any beneficial owner of the Intended Licensee shall notify the Department of its intent to acquire an ownership interest in another general hospital in Connecticut (other than Rockville General Hospital or Waterbury Hospital) or any other state.
4. Within sixty (60) days of the effective date of this Order, Prospect or a subsidiary shall, on behalf of the Intended Licensee, execute a contract with an Independent Monitor ("IM") pre-approved in writing by the FLIS and OHCA. The duties of the IM shall be performed by a single individual unless otherwise approved by the Department. Prospect or its subsidiary shall pay the cost of the IM and all other costs necessary to comply with this Order. The IM shall be contracted to monitor other facilities within the Prospect CT Group as required by the Department. The aggregate cost of the IM to monitor all such facilities under all FLIS and OCHA orders entered into in connection with the licensure of the Prospect CT Group shall not exceed $300,000. The IM shall function in accordance with the IM Guidelines except to the extent there is any conflict between this Order and the Guidelines, the Order shall govern. (Exhibit A, copy attached). The IM shall have expertise in hospital administration and operations,

knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals.

5. The IM shall provide services as outlined herein for two (2) years. If the Department determines during the last six months of the first two years of the IM's tenure or within three months after the two year period that the Facility is not in compliance with applicable accepted standards of practice and federal and state statutes and regulations, the services of the IM shall be extended at the direction of the Department for up to one (1) additional year, for an overall total of three (3) years. The Department shall base any decision regarding the extension of time for IM services upon onsite inspections conducted by the Department and based on all other information the Department deems relevant. The terms of the contract executed on behalf of the Intended Licensee with the IM shall include all pertinent provisions, including time frames contained in this Order.

6. In addition to any other remedies available to the Department, noncompliance with any of the provisions of this Order or the OHCA Order, including failure to pay costs associated with the IM's duties shall constitute a violation of this Order and may result in a fine not to exceed one thousand dollars per day.

7. The IM shall conduct an initial assessment of the Intended Licensee's regulatory compliance which identifies areas requiring remediation. The IM shall report any regulatory or statutory violations identified in the initial assessment to FLIS, OHCA and the Intended Licensee. Such assessment shall, at a minimum, include onsite reviews of hospital systems and direct observations of the Facility staffs' performance as further specified in paragraphs eight (8) and nine (9) of the Order.

8. The IM onsite review shall include, but not be limited to, the following professional and hospital services and systems listed below, and the IM shall make recommendations for improvements, when applicable:

   a. Nursing Services;

   b. Infection Control;

   c. Pharmacy;

d. Surgical Services;
e. Emergency Department;
f. Psychiatric Services;
g. Medical Staff;
h. Patient Rights;
i. Medical Services;
j. Medical Records,
k. Quality Assurance and Performance Improvement; and,
l. Facility's professional credentialing process and assessment process for evaluating competency and remediation/monitoring mechanisms.

9. The initial onsite review by the IM shall be scheduled within thirty (30) days of the execution of the contract with the IM and shall include all satellite locations listed on the Facility's license.

10. The IM shall confer with the Intended Licensee's Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Vice President of Quality and Safety and other staff determined by the IM to be necessary to the assessment of care and services and the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations.

11. The IM shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) regarding the Intended Licensee's compliance with applicable state and federal statutes and regulations and provide copies to the Intended Licensee's governing authority, and the Department, including representatives of the FLIS and the OHCA. No party shall be provided with the opportunity to review the report(s) prior to release, and all parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. IM recommendations shall include, as applicable, areas that need to be addressed, continuing onsite consulting initiatives, and any quality of care issues that require remediation.

12. The IM shall make recommendations to the Intended Licensee's governing authority, Chief Executive Officer, Chief Medical Officer, Vice President of Quality and Safety, the East Regional Vice President of Quality and Patient Safety, the Chief Quality

Officer and Chief Nursing Officer, consistent with accepted standards of practice, for improvement in the delivery of direct patient care in the Facility and compliance with regulatory requirements. If the IM and the Intended Licensee are unable to reach an agreement regarding the IM's recommendation(s), the Department, after meeting with the Intended Licensee and the IM, shall make a final determination, which shall be binding on the Intended Licensee.

13. Upon approval by the Department of the recommendations by the IM, the Intended Licensee shall provide the Department with a proposed timeframe for implementation of the IM recommendations, within twenty-one (21) days of receipt of the report(s). The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented in accordance with the Department's approved timeframe.

14. The IM shall assess the function, the duties, responsibilities and level of engagement of the Prospect Eastern Regional Quality and Patient Safety Steering Council ("Council") and the Facility's Quality Assurance and Performance Improvement Committee ("Committee") and shall determine their ability to monitor implementation of any recommendations provided. This assessment will be provided to the Intended Licensee's governing authority and to FLIS and OHCA.

15. The IM shall re-evaluate the Facility, within six (6) months following the completion of the initial Facility evaluation and semi-annually thereafter throughout the tenure of the IM's engagement. The re-evaluation shall determine the Licensee's ability to implement and maintain quality of care and services, implementation of recommendations previously made by the IM and compliance with regulatory requirements. Upon conclusion of said reviews, the IM shall provide Prospect, the Intended Licensee and the Department, including representatives of FLIS and OHCA, with a comprehensive report of said assessments.

16. The IM shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of patients and to secure compliance with applicable federal and state law and regulations and shall not accept any direction or suggestion from Prospect, the Intended Licensee or its employees that will deter or interfere in fulfilling this obligation.

17. Within one hundred eighty (180) days of the effective date of this Order, Prospect, shall:

    a. Collaborate with Facility leadership in identifying initiatives aimed at improving patient care quality and safety;
    b. Collaborate with Facility leadership to build quality, efficiency, effectiveness, and a shared accountability systems model of care;
    c. Collaborate with Facility leadership to ensure ongoing compliance with state and federal laws and regulations;
    d. Collaborate with Facility leadership to strengthen the data and information capabilities of the Facility to ensure quality and data driven quality measures; and,
    e. Collaborate with Facility leadership to ensure sustainment of quality assurance and performance activities, to include but not be limited to, activities that promote a high reliability organization.

18. The Corporate Chief Quality Officer, Regional Vice President of Quality, Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety and/or their designees shall meet with the Department quarterly for the first six (6) months after the effective date of this Order and thereafter once every six (6) months throughout the tenure of the IM. The meetings shall include discussions of issues related to the care and services provided by the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations. After the first meeting, all subsequent meetings may be attended via teleconference except that no out-of-state participant is required to attend any of the meetings in person.

19. Any records maintained in accordance with any state or federal law or regulation or as required by this Order shall be made available to the IM and the Department, upon request. The IM may attend quality assurance and/or peer review committee meetings and utilize information from such meetings and records for making recommendations or reports. Except where mandated by law or to report illegal conduct to the Department, the IM shall not identify the individual providers subject to peer review. Except for such disclosures to the IM, any rights of the Intended Licensee or any

affiliate to claim and exert privilege to quality assurance or peer review documents under state and/or federal law are preserved and not limited or waived by this Order.

20. A Quality Assurance Performance Improvement Program shall be maintained by the Intended Licensee and monitored by the Committee, consist of, at least, the Intended Licensee' s Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety. The Committee shall focus its activities utilizing a structure, process and outcome model. The Committee shall meet at least once every sixty (60) days and as needed to review all reports or complaints relating to patient care and compliance with accepted standards of practice and federal state laws and regulations. During the tenure of the IM, the IM shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Committee shall include, but not be limited to, compliance with this Order and the IM recommendations, determination and adoption of new policies to be implemented by the Intended Licensee's staff to improve patient care practices; provided that all policies shall be subject to review and approval by the Facility's governing authority, the Local Board and as appropriate, Prospect, consistent with the terms of that certain Quality Assurance Commitment Side Letter dated March 28, 2016 by and between Prospect and Eastern Connecticut Health Network, Inc., as amended to the date hereof ("Quality Letter"). In addition, this Committee shall review and revise, as applicable infection control policies and procedures and monitor their implementation. The Committee shall measure and track the implementation of any changes in the Intended Licensee's policies, procedures. and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of Committee meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of three (3) years.

21. During the term of this Order the Intended Licensee shall notify the Department within five (5) business days, if any of the following positions become vacant (if such positions exist, in name or in responsibilities, at the Facility):

    a. Corporate Chief Quality Officer;

b. Regional Vice President of Quality;
c. Director of Survey Readiness Team;
d. Chief Executive Officer;
e. Chief Medical Officer
f. Chief Nursing Officer;
g. Vice President of Quality and Patient Safety; and,
h. Vice President of Patient Care Services.

22. Within five (5) business days of the effective date of this Order, the Intended Licensee, shall provide the names and resumes of the proposed Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety.

23. The Intended Licensee within five (5) business days of the execution of this Order, shall designate an individual to be responsible for all notices and correspondence pursuant to this Order. The name, mailing address, email address and phone number of the designated individual shall be provided to the Department within said timeframe. The Intended Licensee may provide for a substitute or alternate individual with two (2) business days written notice to the Department.

24. Any reports required by this document shall be directed to:

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12 HSR
Hartford, CT 06134-0308

25. All parties agree that this Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. The Intended Licensee agrees that the compliance with all of the terms and conditions of this Order is part of the responsibility of the Intended Licensee's governing authority as set forth in Public Health Code section 19-13-D68(b)(4). The Intended Licensee further agrees that failure to comply with any of the terms and conditions of this Order shall constitute grounds for disciplinary action pursuant to Section 19a-494 of the Connecticut General Statutes Nothing herein shall be construed as limiting the Department's other available legal remedies against the Intended Licensee for violations of this Order or of any other

statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law.

26. The execution of this Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

27. The Intended Licensee agrees that this Pre-Licensure Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the Order is executed or may become available in the future, provided that this stipulation shall not deprive the Intended Licensee and its affiliate entities of any other rights that it may have under the laws of the State of Connecticut or of the United States.

28. Each of the hospitals acquired by Intended Licensee shall provide to the Department a plan of correction within forty-five (45) days of receiving a physical plant inspection report from the Department.

29. The Intended Licensee has consulted with its attorney prior to the execution of this Order.

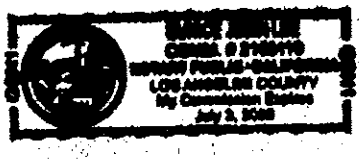
WITNESS WHEREOF, the parties hereto have caused this Pre-Licensure Consent Order to be executed by their respective officers and officials. The undersigned signatories represent and warrant that they are authorized to execute this Pre-Licensure Consent Order on behalf of the party they represent.

By: _____
Ellen J. Shin, Secretary
Prospect Manchester Hospital, Inc.
The Intended Licensee

On this 28th day of September, 2016, before me, personally appeared Ellen J. Shin who acknowledged herself to be the Secretary of the Intended Licensee and that she as Secretary, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing her name as Secretary.

My Commission Expires: July 3, 2020
(If Notary Public)

_____
Notary Public [ ]
Commissioner of the Superior Court [ ]



STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: _____
Barbara Cass, R.N.
Section Chief
Facility Licensing and Investigations Section

September 30, 2016

Exhibit A

FLIS' Independent Monitor Guidelines
For Intended Licensee Prospect Manchester Hospital

Relationship between Independent Monitor (IM) and DPH includes:

- An IM is utilized as a component of DPH's regulatory remedy process. An IM may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and services issues are identified, or when, in connection with a change of ownership, an acquirer is new to the State and has experienced previous compliance issues in another state.
- The IM has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The IM's responsibilities include:
  - Reporting to the Department regarding the Facility's compliance with federal and state law and regulation.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between IM and the Institution:

- The IM maintains a professional and objective relationship with the institutional staff. The IM is a consultant, not an employee of the institution. The IM exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the IM but must cooperate with and respond to requests of the IM related to fulfilling her/his duties.
- The IM's responsibilities, consistent with the terms of the Consent Order, include:
  - Assessment of institution's compliance with recognized standards of practice federal/state laws and regulations.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Reports in accordance with the Consent Order to the institution re: assessments, issues identified, and monitoring of plans of correction.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

In Re: Prospect Rockville Hospital, Inc.
d/b/a Rockville General Hospital
31 Union Street
Vernon, CT 06066

Intended Licensee: Prospect Rockville Hospital, Inc.
d/b/a Rockville General Hospital
Referred to herein as the "Intended Licensee"

PRE-LICENSURE CONSENT ORDER

WHEREAS, Prospect Medical Holdings, Inc. ("Prospect") has obtained certain regulatory approvals to acquire, through one or more subsidiaries, various licensed facilities or operations currently affiliated with Eastern Connecticut Health Network, Inc., including: Manchester Memorial Hospital and Rockville General Hospital ("ECHN Facilities"); and,

WHEREAS, Prospect is seeking to also acquire, through one or more subsidiaries, certain licensed facilities or operations currently affiliated with the Greater Waterbury Health Network, Inc., including the Waterbury Hospital ("GWHN Facilities" and together with the ECHN Facilities referred to as the "Prospect CT Group"); and,

WHEREAS, the Intended Licensee, a subsidiary of Prospect is seeking an initial license to operate a general hospital as defined in Conn. Gen. Stat. § 19a-490(b); and,

WHEREAS, upon the execution of this Pre-Licensure Consent Order ("Order") and after meeting all statutory and regulatory requirements, the Intended Licensee shall be issued a license to operate a General Hospital currently known as Rockville General Hospital ("Facility") by the Connecticut Department of Public Health ("Department").

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department ("FLIS") acting herein and through Barbara Cass, Section Chief, and the Intended Licensee and Prospect hereby stipulate and agree as follows:

1. The Order issued by the Department of Public Health, Office of Health Care Access ("OHCA") dated June 10, 2016 ("OHCA Order") shall be incorporated and made part of this Order.
2. This Order shall remain in effect for three (3) years from the effective date of this Order. The effective date of the Order is October 1, 2016. The issuance of the License shall occur when the Department receives proof, to its satisfaction, that the closing regarding the ECHN Facilities will occur within forty-eight hours of the issuance of the license provided all legal requirements for licensure have been met.
3. During the term of this Order, should the Intended Licensee implement any new patient care services, it shall do so in accordance with Connecticut General Statutes sections 19a-638 through 19a-639b. In addition, for one year after the effective date of this Order, the Intended Licensee and any beneficial owner of the Intended Licensee shall notify the Department of its intent to acquire an ownership interest in another general hospital in Connecticut (other than Rockville General Hospital or Waterbury Hospital) or any other state.
4. Within sixty (60) days of the effective date of this Order, Prospect or a subsidiary shall, on behalf of the Intended Licensee, execute a contract with an Independent Monitor ("IM") pre-approved in writing by the FLIS and OHCA. The duties of the IM shall be performed by a single individual unless otherwise approved by the Department. Prospect or its subsidiary shall pay the cost of the IM and all other costs necessary to comply with this Order. The IM shall be contracted to monitor other facilities within the Prospect CT Group as required by the Department. The aggregate cost of the IM to monitor all such facilities under all FLIS and OCHA orders entered into in connection with the licensure of the Prospect CT Group shall not exceed $300,000. The IM shall function in accordance with the IM Guidelines except to the extent there is any conflict between this Order and the Guidelines, the Order shall govern. (Exhibit A, copy attached). The IM shall have expertise in hospital administration and operations,

knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals.

5. The IM shall provide services as outlined herein for two (2) years. If the Department determines during the last six months of the first two years of the IM's tenure or within three months after the two year period that the Facility is not in compliance with applicable accepted standards of practice and federal and state statutes and regulations, the services of the IM shall be extended at the direction of the Department for up to one (1) additional year, for an overall total of three (3) years. The Department shall base any decision regarding the extension of time for IM services upon onsite inspections conducted by the Department and based on all other information the Department deems relevant. The terms of the contract executed on behalf of the Intended Licensee with the IM shall include all pertinent provisions, including time frames contained in this Order.

6. In addition to any other remedies available to the Department, noncompliance with any of the provisions of this Order or the OHCA Order, including failure to pay costs associated with the IM's duties shall constitute a violation of this Order and may result in a fine not to exceed one thousand dollars per day.

7. The IM shall conduct an initial assessment of the Intended Licensee's regulatory compliance which identifies areas requiring remediation. The IM shall report any regulatory or statutory violations identified in the initial assessment to FLIS, OHCA and the Intended Licensee. Such assessment shall, at a minimum, include onsite reviews of hospital systems and direct observations of the Facility staffs' performance as further specified in paragraphs eight (8) and nine (9) of the Order.

8. The IM onsite review shall include, but not be limited to, the following professional and hospital services and systems listed below, and the IM shall make recommendations for improvements, when applicable:

   a. Nursing Services;

   b. Infection Control;

   c. Pharmacy;

d. Surgical Services;
e. Emergency Department;
f. Psychiatric Services;
g. Medical Staff;
h. Patient Rights;
i. Medical Services;
j. Medical Records,
k. Quality Assurance and Performance Improvement; and,
l. Facility's professional credentialing process and assessment process for evaluating competency and remediation/monitoring mechanisms.

9. The initial onsite review by the IM shall be scheduled within thirty (30) days of the execution of the contract with the IM and shall include all satellite locations listed on the Facility's license.

10. The IM shall confer with the Intended Licensee's Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Vice President of Quality and Safety and other staff determined by the IM to be necessary to the assessment of care and services and the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations.

11. The IM shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) regarding the Intended Licensee's compliance with applicable state and federal statutes and regulations and provide copies to the Intended Licensee's governing authority, and the Department, including representatives of the FLIS and the OHCA. No party shall be provided with the opportunity to review the report(s) prior to release, and all parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. IM recommendations shall include, as applicable, areas that need to be addressed, continuing onsite consulting initiatives, and any quality of care issues that require remediation.

12. The IM shall make recommendations to the Intended Licensee's governing authority, Chief Executive Officer, Chief Medical Officer, Vice President of Quality and Safety, the East Regional Vice President of Quality and Patient Safety, the Chief Quality

Officer and Chief Nursing Officer, consistent with accepted standards of practice, for improvement in the delivery of direct patient care in the Facility and compliance with regulatory requirements. If the IM and the Intended Licensee are unable to reach an agreement regarding the IM's recommendation(s), the Department, after meeting with the Intended Licensee and the IM, shall make a final determination, which shall be binding on the Intended Licensee.

13. Upon approval by the Department of the recommendations by the IM, the Intended Licensee shall provide the Department with a proposed timeframe for implementation of the IM recommendations, within twenty-one (21) days of receipt of the report(s). The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented in accordance with the Department's approved timeframe.

14. The IM shall assess the function, the duties, responsibilities and level of engagement of the Prospect Eastern Regional Quality and Patient Safety Steering Council ("Council") and the Facility's Quality Assurance and Performance Improvement Committee ("Committee") and shall determine their ability to monitor implementation of any recommendations provided. This assessment will be provided to the Intended Licensee's governing authority and to FLIS and OHCA.

15. The IM shall re-evaluate the Facility, within six (6) months following the completion of the initial Facility evaluation and semi-annually thereafter throughout the tenure of the IM's engagement. The re-evaluation shall determine the Licensee's ability to implement and maintain quality of care and services, implementation of recommendations previously made by the IM and compliance with regulatory requirements. Upon conclusion of said reviews, the IM shall provide Prospect, the Intended Licensee and the Department, including representatives of FLIS and OHCA, with a comprehensive report of said assessments.

16. The IM shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of patients and to secure compliance with applicable federal and state law and regulations and shall not accept any direction or suggestion from Prospect, the Intended Licensee or its employees that will deter or interfere in fulfilling this obligation.

17. Within one hundred eighty (180) days of the effective date of this Order, Prospect, shall::

    a. Collaborate with Facility leadership in identifying initiatives aimed at improving patient care quality and safety;
    b. Collaborate with Facility leadership to build quality, efficiency, effectiveness, and a shared accountability systems model of care;
    c. Collaborate with Facility leadership to ensure ongoing compliance with state and federal laws and regulations;
    d. Collaborate with Facility leadership to strengthen the data and information capabilities of the Facility to ensure quality and data driven quality measures; and,
    e. Collaborate with Facility leadership to ensure sustainment of quality assurance and performance activities, to include but not be limited to, activities that promote a high reliability organization.

18. The Corporate Chief Quality Officer, Regional Vice President of Quality, Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety and/or their designees shall meet with the Department quarterly for the first six (6) months after the effective date of this Order and thereafter once every six (6) months throughout the tenure of the IM. The meetings shall include discussions of issues related to the care and services provided by the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations. After the first meeting, all subsequent meetings may be attended via teleconference except that no out-of-state participant is required to attend any of the meetings in person.

19. Any records maintained in accordance with any state or federal law or regulation or as required by this Order shall be made available to the IM and the Department, upon request. The IM may attend quality assurance and/or peer review committee meetings and utilize information from such meetings and records for making recommendations or reports. Except where mandated by law or to report illegal conduct to the Department, the IM shall not identify the individual providers subject to peer review. Except for such disclosures to the IM, any rights of the Intended Licensee or any

affiliate to claim and exert privilege to quality assurance or peer review documents under state and/or federal law are preserved and not limited or waived by this Order.

20. A Quality Assurance Performance Improvement Program shall be maintained by the Intended Licensee and monitored by the Committee, consist of, at least, the Intended Licensee' s Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety. The Committee shall focus its activities utilizing a structure, process and outcome model. The Committee shall meet at least once every sixty (60) days and as needed to review all reports or complaints relating to patient care and compliance with accepted standards of practice and federal state laws and regulations. During the tenure of the IM, the IM shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Committee shall include, but not be limited to, compliance with this Order and the IM recommendations, determination and adoption of new policies to be implemented by the Intended Licensee's staff to improve patient care practices; provided that all policies shall be subject to review and approval by the Facility's governing authority, the Local Board and as appropriate, Prospect, consistent with the terms of that certain Quality Assurance Commitment Side Letter dated March 28, 2016 by and between Prospect and Eastern Connecticut Health Network, Inc., as amended to the date hereof ("Quality Letter"). In addition, this Committee shall review and revise, as applicable infection control policies and procedures and monitor their implementation. The Committee shall measure and track the implementation of any changes in the Intended Licensee's policies, procedures, and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of Committee meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of three (3) years.

21. During the term of this Order the Intended Licensee shall notify the Department within five (5) business days, if any of the following positions become vacant (if such positions exist, in name or in responsibilities, at the Facility):

    a. Corporate Chief Quality Officer;

b. Regional Vice President of Quality;
c. Director of Survey Readiness Team;
d. Chief Executive Officer;
e. Chief Medical Officer
f. Chief Nursing Officer;
g. Vice President of Quality and Patient Safety; and,
h. Vice President of Patient Care Services.

22. Within five (5) business days of the effective date of this Order, the Intended Licensee, shall provide the names and resumes of the proposed Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety.

23. The Intended Licensee within five (5) business days of the execution of this Order, shall designate an individual to be responsible for all notices and correspondence pursuant to this Order. The name, mailing address, email address and phone number of the designated individual shall be provided to the Department within said timeframe. The Intended Licensee may provide for a substitute or alternate individual with two (2) business days written notice to the Department.

24. Any reports required by this document shall be directed to:

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12 HSR
Hartford, CT 06134-0308

25. All parties agree that this Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. The Intended Licensee agrees that the compliance with all of the terms and conditions of this Order is part of the responsibility of the Intended Licensee's governing authority as set forth in Public Health Code section 19-13-D68(b)(4). The Intended Licensee further agrees that failure to comply with any of the terms and conditions of this Order shall constitute grounds for disciplinary action pursuant to Section 19a-494 of the Connecticut General Statutes Nothing herein shall be construed as limiting the Department's other available legal remedies against the Intended Licensee for violations of this Order or of any other

statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law.

26. The execution of this Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

27. The Intended Licensee agrees that this Pre-Licensure Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the Order is executed or may become available in the future, provided that this stipulation shall not deprive the Intended Licensee and its affiliate entities of any other rights that it may have under the laws of the State of Connecticut or of the United States.

28. Each of the hospitals acquired by Intended Licensee shall provide to the Department a plan of correction within forty-five (45) days of receiving a physical plant inspection report from the Department.

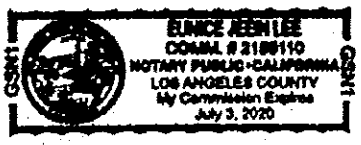
29. The Intended Licensee has consulted with its attorney prior to the execution of this Order.

WITNESS WHEREOF, the parties hereto have caused this Pre-Licensure Consent Order to be executed by their respective officers and officials. The undersigned signatories represent and warrant that they are authorized to execute this Pre-Licensure Consent Order on behalf of the party they represent.

By: _____
Ellen J. Shin, Secretary
Prospect Rockville Hospital, Inc.
The Intended Licensee

On this 28th day of September, 2016, before me, personally appeared Ellen J. Shin who acknowledged herself to be the Secretary of the Intended Licensee and that she as Secretary, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing her name as Secretary.

My Commission Expires: July 3, 2020
(If Notary Public)



_____
Notary Public [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: _____
Barbara Cass, R.N.
Section Chief
Facility Licensing and Investigations Section

September 30, 2016

Exhibit A

FLIS' Independent Monitor Guidelines
For Intended Licensee Prospect Manchester Hospital

Relationship between Independent Monitor (IM) and DPH includes:

- An IM is utilized as a component of DPH's regulatory remedy process. An IM may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and services issues are identified, or when, in connection with a change of ownership, an acquirer is new to the State and has experienced previous compliance issues in another state.
- The IM has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The IM's responsibilities include:
  - Reporting to the Department regarding the Facility's compliance with federal and state law and regulation.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between IM and the Institution:

- The IM maintains a professional and objective relationship with the institutional staff. The IM is a consultant, not an employee of the institution. The IM exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the IM but must cooperate with and respond to requests of the IM related to fulfilling her/his duties.
- The IM's responsibilities, consistent with the terms of the Consent Order, include:
  - Assessment of institution's compliance with recognized standards of practice federal/state laws and regulations.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Reports in accordance with the Consent Order to the institution re: assessments, issues identified, and monitoring of plans of correction.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

In Re: Prospect Waterbury, Inc.
d/b/a The Waterbury Hospital
64 Robbins Street
Waterbury, CT 06708

Intended Licensee: Prospect Waterbury, Inc.
d/b/a The Waterbury Hospital
Referred to herein as the "Intended Licensee"

PRE-LICENSURE CONSENT ORDER

WHEREAS, Prospect Medical Holdings, Inc. ("Prospect") has obtained certain regulatory approvals to acquire, through one or more subsidiaries, various licensed facilities or operations currently affiliated with Eastern Connecticut Health Network, Inc., including: Manchester Memorial Hospital and Rockville General Hospital ("ECHN Facilities"); and,

WHEREAS, Prospect is seeking to also acquire, through one or more subsidiaries, certain licensed facilities or operations currently affiliated with the Greater Waterbury Health Network, Inc., including the Waterbury Hospital ("GWHN Facilities" and together with the ECHN Facilities referred to as the "Prospect CT Group"); and,

WHEREAS, the Intended Licensee, a subsidiary of Prospect is seeking an initial license to operate a general hospital as defined in Conn. Gen. Stat. § 19a-490(b); and,

WHEREAS, upon the execution of this Pre-Licensure Consent Order ("Order") and after meeting all statutory and regulatory requirements, the Intended Licensee shall be issued a license to operate a General Hospital currently known as The Waterbury Hospital ("Facility") by the Connecticut Department of Public Health ("Department").

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department ("FLIS") acting herein and through Barbara Cass, Section Chief, and the Intended Licensee and Prospect hereby stipulate and agree as follows:

1. The Order issued by the Department of Public Health, Office of Health Care Access ("OHCA") dated June 10, 2016 ("OHCA Order") shall be incorporated and made part of this Order.
2. This Order shall remain in effect for three (3) years from the effective date of this Order. The effective date of the Order is October 1, 2016. The issuance of the License shall occur when the Department receives proof, to its satisfaction, that the closing regarding the ECHN Facilities will occur within forty-eight hours of the issuance of the license provided all legal requirements for licensure have been met.
3. During the term of this Order, should the Intended Licensee implement any new patient care services, it shall do so in accordance with Connecticut General Statutes sections 19a-638 through 19a-639b. In addition, for one year after the effective date of this Order, the Intended Licensee and any beneficial owner of the Intended Licensee shall notify the Department of its intent to acquire an ownership interest in another general hospital in Connecticut (other than Rockville General Hospital or Waterbury Hospital) or any other state.
4. Within sixty (60) days of the effective date of this Order, Prospect or a subsidiary shall, on behalf of the Intended Licensee, execute a contract with an Independent Monitor ("IM") pre-approved in writing by the FLIS and OHCA. The duties of the IM shall be performed by a single individual unless otherwise approved by the Department. Prospect or its subsidiary shall pay the cost of the IM and all other costs necessary to comply with this Order. The IM shall be contracted to monitor other facilities within the Prospect CT Group as required by the Department. The aggregate cost of the IM to monitor all such facilities under all FLIS and OCHA orders entered into in connection with the licensure of the Prospect CT Group shall not exceed $300,000. The IM shall function in accordance with the IM Guidelines except to the extent there is any conflict between this Order and the Guidelines, the Order shall govern. (Exhibit A, copy attached). The IM shall have expertise in hospital administration and operations,

knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals.

5. The IM shall provide services as outlined herein for two (2) years. If the Department determines during the last six months of the first two years of the IM's tenure or within three months after the two year period that the Facility is not in compliance with applicable accepted standards of practice and federal and state statutes and regulations, the services of the IM shall be extended at the direction of the Department for up to one (1) additional year, for an overall total of three (3) years. The Department shall base any decision regarding the extension of time for IM services upon onsite inspections conducted by the Department and based on all other information the Department deems relevant. The terms of the contract executed on behalf of the Intended Licensee with the IM shall include all pertinent provisions, including time frames contained in this Order.

6. In addition to any other remedies available to the Department, noncompliance with any of the provisions of this Order or the OHCA Order, including failure to pay costs associated with the IM's duties shall constitute a violation of this Order and may result in a fine not to exceed one thousand dollars per day.

7. The IM shall conduct an initial assessment of the Intended Licensee's regulatory compliance which identifies areas requiring remediation. The IM shall report any regulatory or statutory violations identified in the initial assessment to FLIS, OHCA and the Intended Licensee. Such assessment shall, at a minimum, include onsite reviews of hospital systems and direct observations of the Facility staffs' performance as further specified in paragraphs eight (8) and nine (9) of the Order.

8. The IM onsite review shall include, but not be limited to, the following professional and hospital services and systems listed below, and the IM shall make recommendations for improvements, when applicable:

   a. Nursing Services;

   b. Infection Control;

   c. Pharmacy;

d. Surgical Services;
e. Emergency Department;
f. Psychiatric Services;
g. Medical Staff;
h. Patient Rights;
i. Medical Services;
j. Medical Records,
k. Quality Assurance and Performance Improvement; and,
l. Facility's professional credentialing process and assessment process for evaluating competency and remediation/monitoring mechanisms.

9. The initial onsite review by the IM shall be scheduled within thirty (30) days of the execution of the contract with the IM and shall include all satellite locations listed on the Facility's license.

10. The IM shall confer with the Intended Licensee's Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Vice President of Quality and Safety and other staff determined by the IM to be necessary to the assessment of care and services and the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations.

11. The IM shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) regarding the Intended Licensee's compliance with applicable state and federal statutes and regulations and provide copies to the Intended Licensee's governing authority, and the Department, including representatives of the FLIS and the OHCA. No party shall be provided with the opportunity to review the report(s) prior to release, and all parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. IM recommendations shall include, as applicable, areas that need to be addressed, continuing onsite consulting initiatives, and any quality of care issues that require remediation.

12. The IM shall make recommendations to the Intended Licensee's governing authority, Chief Executive Officer, Chief Medical Officer, Vice President of Quality and Safety, the East Regional Vice President of Quality and Patient Safety, the Chief Quality

Officer and Chief Nursing Officer, consistent with accepted standards of practice, for improvement in the delivery of direct patient care in the Facility and compliance with regulatory requirements. If the IM and the Intended Licensee are unable to reach an agreement regarding the IM's recommendation(s), the Department, after meeting with the Intended Licensee and the IM, shall make a final determination, which shall be binding on the Intended Licensee.

13. Upon approval by the Department of the recommendations by the IM, the Intended Licensee shall provide the Department with a proposed timeframe for implementation of the IM recommendations, within twenty-one (21) days of receipt of the report(s). The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented in accordance with the Department's approved timeframe.

14. The IM shall assess the function, the duties, responsibilities and level of engagement of the Prospect Eastern Regional Quality and Patient Safety Steering Council ("Council") and the Facility's Quality Assurance and Performance Improvement Committee ("Committee") and shall determine their ability to monitor implementation of any recommendations provided. This assessment will be provided to the Intended Licensee's governing authority and to FLIS and OHCA.

15. The IM shall re-evaluate the Facility, within six (6) months following the completion of the initial Facility evaluation and semi-annually thereafter throughout the tenure of the IM's engagement. The re-evaluation shall determine the Licensee's ability to implement and maintain quality of care and services, implementation of recommendations previously made by the IM and compliance with regulatory requirements. Upon conclusion of said reviews, the IM shall provide Prospect, the Intended Licensee and the Department, including representatives of FLIS and OHCA, with a comprehensive report of said assessments.

16. The IM shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of patients and to secure compliance with applicable federal and state law and regulations and shall not accept any direction or suggestion from Prospect, the Intended Licensee or its employees that will deter or interfere in fulfilling this obligation.

17. Within one hundred eighty (180) days of the effective date of this Order, Prospect, shall::

    a. Collaborate with Facility leadership in identifying initiatives aimed at improving patient care quality and safety;
    b. Collaborate with Facility leadership to build quality, efficiency, effectiveness, and a shared accountability systems model of care;
    c. Collaborate with Facility leadership to ensure ongoing compliance with state and federal laws and regulations;
    d. Collaborate with Facility leadership to strengthen the data and information capabilities of the Facility to ensure quality and data driven quality measures; and,
    e. Collaborate with Facility leadership to ensure sustainment of quality assurance and performance activities, to include but not be limited to, activities that promote a high reliability organization.

18. The Corporate Chief Quality Officer, Regional Vice President of Quality, Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety and/or their designees shall meet with the Department quarterly for the first six (6) months after the effective date of this Order and thereafter once every six (6) months throughout the tenure of the IM. The meetings shall include discussions of issues related to the care and services provided by the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations. After the first meeting, all subsequent meetings may be attended via teleconference except that no out-of-state participant is required to attend any of the meetings in person.

19. Any records maintained in accordance with any state or federal law or regulation or as required by this Order shall be made available to the IM and the Department, upon request. The IM may attend quality assurance and/or peer review committee meetings and utilize information from such meetings and records for making recommendations or reports. Except where mandated by law or to report illegal conduct to the Department, the IM shall not identify the individual providers subject to peer review. Except for such disclosures to the IM, any rights of the Intended Licensee or any

affiliate to claim and exert privilege to quality assurance or peer review documents under state and/or federal law are preserved and not limited or waived by this Order.

20. A Quality Assurance Performance Improvement Program shall be maintained by the Intended Licensee and monitored by the Committee, consist of, at least, the Intended Licensee' s Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety. The Committee shall focus its activities utilizing a structure, process and outcome model. The Committee shall meet at least once every sixty (60) days and as needed to review all reports or complaints relating to patient care and compliance with accepted standards of practice and federal state laws and regulations. During the tenure of the IM, the IM shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Committee shall include, but not be limited to, compliance with this Order and the IM recommendations, determination and adoption of new policies to be implemented by the Intended Licensee's staff to improve patient care practices; provided that all policies shall be subject to review and approval by the Facility's governing authority, the Local Board and as appropriate, Prospect, consistent with the terms of that certain Quality Assurance Commitment Side Letter dated March 28, 2016 by and between Prospect and Eastern Connecticut Health Network, Inc., as amended to the date hereof ("Quality Letter"). In addition, this Committee shall review and revise, as applicable infection control policies and procedures and monitor their implementation. The Committee shall measure and track the implementation of any changes in the Intended Licensee's policies, procedures, and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of Committee meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of three (3) years.

21. During the term of this Order the Intended Licensee shall notify the Department within five (5) business days, if any of the following positions become vacant (if such positions exist, in name or in responsibilities, at the Facility):

    a. Corporate Chief Quality Officer;

b. Regional Vice President of Quality;

c. Director of Survey Readiness Team;

d. Chief Executive Officer;

e. Chief Medical Officer

f. Chief Nursing Officer;

g. Vice President of Quality and Patient Safety; and,

h. Vice President of Patient Care Services.

22. Within five (5) business days of the effective date of this Order, the Intended Licensee, shall provide the names and resumes of the proposed Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety.

23. The Intended Licensee within five (5) business days of the execution of this Order, shall designate an individual to be responsible for all notices and correspondence pursuant to this Order. The name, mailing address, email address and phone number of the designated individual shall be provided to the Department within said timeframe. The Intended Licensee may provide for a substitute or alternate individual with two (2) business days written notice to the Department.

24. Any reports required by this document shall be directed to:

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12 HSR
Hartford, CT 06134-0308

25. All parties agree that this Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. The Intended Licensee agrees that the compliance with all of the terms and conditions of this Order is part of the responsibility of the Intended Licensee's governing authority as set forth in Public Health Code section 19-13-D68(b)(4). The Intended Licensee further agrees that failure to comply with any of the terms and conditions of this Order shall constitute grounds for disciplinary action pursuant to Section 19a-494 of the Connecticut General Statutes Nothing herein shall be construed as limiting the Department's other available legal remedies against the Intended Licensee for violations of this Order or of any other

statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law.

26. The execution of this Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

27. The Intended Licensee agrees that this Pre-Licensure Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the Order is executed or may become available in the future, provided that this stipulation shall not deprive the Intended Licensee and its affiliate entities of any other rights that it may have under the laws of the State of Connecticut or of the United States.

28. Each of the hospitals acquired by Intended Licensee shall provide to the Department a plan of correction within forty-five (45) days of receiving a physical plant inspection report from the Department.

29. The Intended Licensee has consulted with its attorney prior to the execution of this Order.

WITNESS WHEREOF, the parties hereto have caused this Pre-Licensure Consent Order to be executed by their respective officers and officials. The undersigned signatories represent and warrant that they are authorized to execute this Pre-Licensure Consent Order on behalf of the party they represent.

By: _____
Ellen J. Shin, Secretary
Prospect Waterbury, Inc.
The Intended Licensee

On this 28th day of September, 2016, before me, personally appeared Ellen J. Shin who acknowledged herself to be the Secretary of the Intended Licensee and that she as Secretary, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing her name as Secretary.

My Commission Expires: July 2, 2020
(If Notary Public)

_____
Notary Public [ ]
Commissioner of the Superior Court [ ]

EUNICE JEEN LEE
COMM. # 2150110
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Commission Expires
July 2, 2020

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: _____
Barbara Cass, R.N.
Section Chief
Facility Licensing and Investigations Section

September 30, 2016

Exhibit A

FLIS' Independent Monitor Guidelines
For Intended Licensee Prospect Manchester Hospital

Relationship between Independent Monitor (IM) and DPH includes:

- An IM is utilized as a component of DPH's regulatory remedy process. An IM may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and services issues are identified, or when, in connection with a change of ownership, an acquirer is new to the State and has experienced previous compliance issues in another state.
- The IM has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The IM's responsibilities include:
  - Reporting to the Department regarding the Facility's compliance with federal and state law and regulation.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between IM and the Institution:

- The IM maintains a professional and objective relationship with the institutional staff. The IM is a consultant, not an employee of the institution. The IM exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the IM but must cooperate with and respond to requests of the IM related to fulfilling her/his duties.
- The IM's responsibilities, consistent with the terms of the Consent Order, include:
  - Assessment of institution's compliance with recognized standards of practice federal/state laws and regulations.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Reports in accordance with the Consent Order to the institution re: assessments, issues identified, and monitoring of plans of correction.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of November ___, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") (together, the "Covered Entities") and Colleen Smith, MSN, RN, NEA-BC ("Business Associate")

R E C I T A L S:

WHEREAS, the Business Associate and Covered Entities have entered into and may enter into one or more agreements (the "Agreement(s)") under which the Business Associate performs or assists the Covered Entities with a function or activity involving the Use or Disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entities and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

WHEREAS, the HIPAA Standards require that the Covered Entities obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information Used or Disclosed by the Business Associate in the course of performing services pursuant to the Agreement(s).

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

1. <u>Definitions</u>

a) HIPAA Rules shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

b) The following terms Used in this business Associate Agreement shall have the same meaning as those terms defined in the HIPAA Standards: Business Associate, Covered Entity, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

c) The Covered Entities and the Business Associate acknowledge and agree that capitalized terms Used, but not otherwise defined, herein are as defined in the HIPAA Standards;

2. **Obligations and Activities of Business Associate**

a) Business Associate shall not Use or further Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as required by law.

b) Business Associate shall Use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent Use or Disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

c) Business Associate shall immediately report to Covered Entities any Use or Disclosure of Protected Health Information or individually identifiable information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information as required and any Security Incident of which the Business Associate becomes aware. Business Associate shall take any reasonable action necessary or requested by the Covered Entities to mitigate, to the extent practicable, any harmful effect that is known to Business Associate.

d) In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate's notice to Covered Entities of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, or disclosed. Business Associate shall also provide Covered Entities any other available information that the Covered Entities are required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any reasonable action necessary as requested by the Covered Entities to assist Covered Entities in complying with any applicable Breach notification requirements.

e) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor that creates, maintains transmits, or receives Protected Health Information on behalf of Covered Entities agrees to the same restrictions, conditions and requirements that apply through to Business Associate with respect to such information.

f) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:

(i) provide access or make available to Covered Entities Protected Health Information in a Designated Record Set, to Covered Entities or to an Individual, per Covered Entities' direction in order to meet the requirements under 45 C.F.R. § 164.524; and

(ii) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entities direct or agree to

pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual in the time and manner designated by Covered Entity, or take other measures as necessary to satisfy Covered Entities' obligations under 45 C.F.R. 164.526.

g) Business Associate shall maintain and make available to Covered Entity information pertaining to Disclosures of Protected Health Information by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of Disclosures of Protected Health Information made by Business Associate, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.

h) To the extent Business Associate is to carry out one or more of Covered Entities' obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

i) Business Associate shall make internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created, maintained or received by Business Associate on behalf of Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entities' or Business Associate's compliance with the HIPAA Rules.

j) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is Used or Disclosed only as authorized under the HIPAA Rules and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Rules that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Rules. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Rules and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper Use and/or Disclosure of an Individual's information.

k) In the event that Business Associate has knowledge of a Covered Entity's breach of the HIPAA Rules, Business Associate agrees to notify Covered Entity and take reasonable steps to cure such breach.

l) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.

3. Permitted Uses and Disclosures by Business Associate

a) Business Associate may Use or Disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, a Covered Entity as specified in the Agreement(s), provided that such Use or Disclosure would not violate the HIPAA Rules if done by the Covered Entity.

b) Business Associate may Use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c) Business Associate may Disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and will be Used or further Disclosed only as Required by Law or for the purpose for which it was initially Disclosed to the recipient, and the recipient notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d) Except as otherwise permitted by the HIPAA Rules, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, Business Associate agrees to make Uses and Disclosures and requests for protected health information consistent with the Minimum Necessary to accomplish the intended purpose of such Use, Disclosure, or request.

e) Except as otherwise permitted by the HIPAA Rules, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless the Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.

f) If an Individual requests that Business Associate restrict the Disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the Disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

g) Except as otherwise limited in this Business Associate Agreement, Business Associate may Use and Disclose Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

4. Obligations of Covered Entities

a) Covered Entities shall provide Business Associate with the Notice of Privacy Practices that Covered Entities produce in accordance with 45 C.F.R. § 164.520, as well as provide any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.

b) Covered Entities shall provide Business Associate with any changes in, or revocation of, permission by Individual to Use or Disclose Protected Health Information, if such changes affect Business Associate's permitted or required Uses and Disclosures.

c) Covered Entities shall notify Business Associate of any restriction to the Use or Disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522.

d) Covered Entities shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by Covered Entities.

5. Term and Termination

a) Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate at to a Covered Entity when all of the Protected Health Information provided by the Covered Entity to Business Associate, or created, maintained, or received by Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b) Termination for Cause. Upon a Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, the Covered Entity shall provide an opportunity for Business Associate to cure

the breach or end the violation. The Covered Entity shall terminate the Business Associate Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. The Covered Entity may immediately terminate the Business Associate Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in its reasonable discretion.

c) Effect of Termination.

(i) Except as provided in this subsection, upon termination of the Agreement(s) or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entities, or created, maintained or received by Business Associate on behalf of Covered Entities that the Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entities notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(iii) The parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entities and the Business Associate. The parties further agree that the Covered Entities would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entities shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

(iv) Survival. The obligations of Business Associate under this Section shall survive the termination of this Business Associate Agreement.

6. **Miscellaneous**

a) Interpretation. Any ambiguity in this Business Associate Agreement shall be interpreted in a manner that permits the parties to comply with the HIPAA Rules.

b) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.

c) Amendment. Any party shall have the right to amend this Business Associate Agreement by providing written notice to the other parties in order to bring it into compliance with any law or regulation enacted or promulgated regarding the protection of health information that is any way inconsistent with the terms of this Business Associate Agreement or interferes with the parties' obligations with respect to the protection of health information.

d) Application of State Law. Where any applicable provision of Connecticut State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Rules, the parties shall comply with the applicable provisions of Connecticut State law.

e) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

f) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The parties agree that venue shall lie in Federal and State courts in the State in which the Covered Entities maintain their principal places of business, without regard to conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

g) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the addresses set forth below and shall be considered given upon delivery.

Chief Compliance and Privacy Officer
Prospect ECHN, Inc.

71 Haynes Street
Manchester, CT 06040

Chief Compliance Officer
Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

h) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement(s), Business Associate shall indemnify, hold harmless and defend Covered Entities from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any Use or Disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by Covered Entitles in providing required breach notifications.

IN WITNESS WHEREOF, the parties hereto have executed this Business Associate Agreement as of the Effective Date.

BUSINESS ASSOCIATE

By:_____
Printed Name: Colleen Smith, MSN, RN, NEA-BC
Title:
Date:

COVERED ENTITY
PROSPECT ECHN, INC.

By:_____
Printed Name:
Title:
Date:

COVERED ENTITY
PROSPECT WATERBURY, INC.

By:_____
Printed Name:
Title:
Date:

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 4:00 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Schedule conference call

From: Olejarz, Barbara
Sent: Thursday, November 17, 2016 10:45 AM
To: Jennifer O'Donnell
Cc: Martone, Kim; Cotto, Carmen; Roberts, Karen
Subject: RE: Schedule conference call

Hi Jennifer,

From OHCA there will be Kim Martone, Karen Roberts and Carmen Cotto. It's okay with OHCA that only Michele call in unless there is someone else that Michele would like to have participate in the conference call. The call in number is Kim's office number at 860- 418-7029. I am sending out a calendar request.

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Thursday, November 17, 2016 10:34 AM
To: Olejarz, Barbara <Barbara.Olejarz@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Michele Volpe <mmv@bvmlaw.com>
Subject: RE: Schedule conference call

Yes, Michele is available and can participate on the call. Is there anyone else that you need to participate on the call?

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

Greer, Leslie

From: Roberts, Karen
Sent: Tuesday, November 29, 2016 11:36 AM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Prospect Medical Holdings

Please add to the two Prospect CONs (ECHN and Waterbury). Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

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From: Cass, Barbara
Sent: Monday, November 28, 2016 1:17 PM
To: Martone, Kim
Cc: Roberts, Karen; Newton, Susan; Ortelle, Donna; Furniss, Wendy
Subject: Prospect Medical Holdings

Dear Kim:

The Facility Licensing and Investigations Section has met with Colleen Smith, M.S.N., R.N., NEA-BC and has approved her as capable of serving in the capacity of the IM, if the Office of Health Care Access is also in agreement as it relates to the Prospect Medical Holdings acquisition in Connecticut. She has extensive experience in the overall management of hospitals and specific experiences as the chief nursing officer of a magnet hospital.

Best,

Barbara

Barbara S. Cass, R.N.
Section Chief
Facility Licensing and Investigations Section
State of Connecticut, Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Telephone: 860-509-7609

Greer, Leslie

From: Hyland, Irene <ihyland@wtbyhosp.org>
Sent: Wednesday, November 30, 2016 3:00 PM
To: User, OHCA
Cc: Buckley, Katherine; DiStefano, Guy; Frank.Saidara@prospectmedical.com
Subject: Docket Number: 15-32017-486
Attachments: GWHN Asset Transfer Ltr.pdf

Thank you,

Irene Hyland
Executive Assistant to Guy DiStefano, VP and Chief Financial Officer
Finance Department Assistant

Phone: 203-573-7520
Fax: 203-573-7325
Email: ihyland@wtbyhosp.org

WATERBURY HOSPITAL
64 Robbins Street • Waterbury, CT 06708

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Greater Waterbury Health Network

A family of Waterbury Hospital services

Access Rehab Centers, LLC
Children's Center of The Greater Waterbury Health Network, Inc.
FamilyCare, PC (Middlebury, Naugatuck, Waterbury, Watertown and Woodbury)
GWHN & Physicians, Inc.
Greater Waterbury Imaging Center, LLP
Greater Waterbury Management Resources, Inc.
Harold Leever Regional Cancer Center, Inc.
Imaging Partners, LLC
Reed Ambulatory Surgery Center, Inc.
VNA Health at Home, Inc.
The Waterbury Hospital

November 30, 2016

VIA EMAIL DELIVERY

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32017-486**

Project Title: **Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Brancifort:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Eight (8), Condition Number Nine (9) and Condition Number Ten (10) regarding the transfer of assets of Greater Waterbury Health Network, Inc. (GWHN) to Prospect Medical Holdings, Inc. (PMH). Please note that the transaction closed on October 1, 2016 ("Closing Date").

Condition Number Eight (8) requires that starting on November 30, 2016, for the reporting period of April 1, 2016 through September 30, 2016 that PMH provide a report on the capital investments ("Capital Investment Report") it has made in the New GWHN. The Capital Investment Report shall include the following in a format to be agreed upon:

a. A list of the capital expenditures that have been made in the prior one hundred and eighty days (180) days with descriptions of each associated project; and

b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending, and startup/operation dates); and

c. The dates and amounts of withdrawals from each of the New GWHN's operating account and/or any other sources of funding used to fulfill the Capital Commitment.

Condition Number Nine (9) requires that by November 30, 2016, for the reporting period of April 1, 2016 through September 30, 2016 that PMH provide a report for New GWHN with the following information:

a. The cost saving totals achieved in the following Operating Expense Categories for New GWHN and New Hospital: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest

Expense, Malpractice Expense, Utilities, Business Expenses, and other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRIS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. The major cost savings achieved for each expense category for the semi-annual period; and

2. The effect of cost savings on the clinical quality of care.

b. A Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New GWHNN and New Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

Condition Number Ten (10) requires that by November 30, 2016, for the reporting period of April 1, 2016 through September 30, 2016 that PMH provide a financial measurement report as specified in the Certificate of Need Final Decision.

As the reporting periods for both above Conditions are for a period prior to the Closing Date, there is no relevant data to report at this time. Prospect Medical Holdings did not acquire GWHN until October 1, 2016 and was therefore not in a position to make capital investments in the hospitals or demonstrate cost savings. A filing will be made on or before May 31, 2017 with the required information for capital investments made, costs saving achieved and the financial measurement report for the period beginning on October 1, 2016 through March 31, 2017.

If you have any questions or need anything further, please feel free to contact me at (203) 573-7280.

Very truly yours,

Guy Distefeno
Chief Financial Officer
Greater Waterbury Health Network

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Michele M. Volpe, Bershtein, Volpe & McKeon, P.C.
Darlene Stromstad, CEO, GWHN
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Greer, Leslie

From:	Colleen Smith <colleen713.smith@gmail.com>
Sent:	Friday, December 09, 2016 10:33 AM
To:	User, OHCA
Cc:	Colleen Smith
Subject:	GWHN Docket # 15-32017-486
Attachments:	Nursing Consulting Partners Waterbury Health Agreement Work plan CS11.30 final.docx; ATT00001.htm

To Whom It May Concern,
Attached please find the Independent Monitor Work Plan for the OHCA Final Decision for Greater Waterbury Health Network.
Thank you,
Colleen Smith
Independent Monitor

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

NURSING CONSULTING PARTNERS
Sustainable Results for Healthcare Solutions

GREATER WATERBURY HEALTH NETWOR WOR PLAN 11 28 16

INDEPENDENT MONITORING PROCEDURES (per Docket Number 15-32016-486)

OHCA Condition	IM Action
CON Condition 4: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the Health Needs Plan) for continuing to support and implement GWHN s 2016 Community Health Needs Assessment (CHNA) and for conducting the New Hospitals next comprehensive study of community health needs in the Service Area (the Community Health Needs Study or Study). The Health Needs Plan shall describe in detail at least the following: (i) the data that will be collected and analy ed to systematically assess health status Indicators of the Service Area; (ii) the identity of key community stakeholders and health organi ations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation; (iii) the ualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined; (iv) the fre uency with which the Study will be repeated; (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the Implementation Strategy) will be distributed to the community; and (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospitals.	IM will obtain a copy of the Plan, verify timely submission, verify that it incorporated the re uired elements.
CON Condition 5: Within three (3) years following the Closing Date, PMH shall participate with New GWHN and the New Hospitals, and the key community stakeholders and health organi ations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utili e Healthy Connecticut State Health Improvement Plan data and priorities as	IM will obtain a copy of the Study, verify timely submission, verify that it incorporated the re uired elements and was published on the website.

the starting point for the Study (available at http://www.ct.gov/dph/lib/dph/state_health_planning/ship/hct2020/hct2020_state_hlth_impv_032514.pdf) as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on New Hospital's website. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement GWHN's current CHNA for the Hospital. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*	
CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospital for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will obtain a copy of the Plan and verify it incorporated the required elements.
CON Condition 7: Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospital. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will verify proper notification to OHCA within 10 days of any plan to reallocate inpatient beds and relocation of outpatient services. IM will assure timely publication on New Hospitals website within 10 days of decision to reallocate or relocate services.
CON Condition 8: Within one hundred and eighty (180) days	IM will obtain the Plan, read the

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New Hospital and its affiliates from the Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and c. The dates and amounts of withdrawals from each of the New Hospital's operating account and/or any other sources of funding used to fulfill the Capital Commitment. The reports shall be signed by the New GWHN's Chief Financial Officer. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 38-45*	plan and verify that expenditures/investments made are in accordance with the Plan. IM will confirm timely submissions of all required reports.
<u>CON Condition 9:</u> For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for New GWHN and the New Hospital, respectively: a. The cost saving totals achieved in the following Operating Expense Categories for GWHN and New Hospital: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:	IM will review the PMH filings regarding cost savings achieved in accordance with a. 1-2 and b. of Condition 9.

1. the major cost savings achieved for each expense category for the semi-annual period; and 2. the effect of these cost savings on the clinical quality of care. b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New GWHN and New Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100-150, 300-350 or successor reports. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*	
CON Condition 10: For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New Prospect Waterbury, Inc., New MMH and New RGH, respectively. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Liquidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to equity, long-term debt to capitalization, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) **Additional Statistics** to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements used in the calculation), unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	IM will obtain the financial measurement report and read to confirm that the required elements are addressed in the report; IM will confirm the timely submission of each report.
CON Condition 11: PMH shall ensure that the New Hospital maintains and adheres to GWHN's current policies regarding charity care, indigent care and community volunteer services at New MMH and New RGH after the Closing Date all as consistent	IM will obtain copies of the relevant financial assistance policies, read and confirm that as adopted financial assistance

with state and federal law or adopt other policies that are at least as generous and benevolent to the community as GWHN s current policies. These policies shall be posted on the website of the New Hospital and as additionally re uired by applicable law. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	policies (or policies at least as generous as these policies) using management approval of the policies as evidence. After verifying that this step has been properly completed, IM will confirm that these policies are properly posted on website
CON Condition 12: For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of New Hospital within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of the New Hospital simultaneously with their submission to OHCA. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	After obtaining original policies on charity care, indigent care, and community volunteer services, IM will read and assess these policies on an annual basis for changes. When changes are made to these policies, IM will confirm OHCA is notified (as re uired) and revised policies are posted to the website.
CON Condition 13: PMH shall maintain community benefit programs and community building activities for the New Hospital for three (3) years after the Closing Date consistent with the Hospital s most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as GWHN s current programs, and PMH shall apply a 1 increase per year for the next three (3) years toward community building activities in terms of dollars spent. In determining the New Hospital s participation in and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the New Hospital s website. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain most recent Schedule H of IRS Form 990 to act as a baseline. IM will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase re uirement has been met. IM will also obtain the report summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. IM will confirm that these documents are filed in a timely manner and posted to the website.
CON Condition 14: The New Hospital agrees to comply with the following general community benefit standards for at	IM will verify the New Hospitals compliance with community

least the first three years. (a) the New Hospital shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospital shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusions of other □ualified doctors; (c) the New Hospital shall participate in the Medicare and Medicaid programs; and (d) the New Hospital shall operate 24□7 emergency departments and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); Tr., Testimony of Tom Reardon, President. PMH East on 5/3/16, pp. 103-04*	benefit standards a through d as stated in Condition 14.
CON Condition 15: The New Hospital shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations. Specifically, the New Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the New Hospital shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, New MMH and New RGH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services□Office of Minority Health. For three (3) years following the Closing Date, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition so as to ensure continued access to health care services to the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain and review interpreter services policies and contracts as applicable. Additionally, IM will obtain a cultural competency plan, training, as well as related policies. IM will also obtain report and supporting documents and confirm the timely filing of these materials
CON Condition 16: Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who has experience in hospital administration and regulation, including maintaining □uality control in a High Reliability Organi□ation (□HRO□). The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed □300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations (□FLIS□) section of the Department of Public Health (□DPH□) will approve the Independent Monitor□s appointment. The Independent Monitor shall be engaged for a	IM and PMH will execute a Consulting Services Agreement by the re□uired date. A draft of this Agreement has been provided to OHCA.

minimum period of two (2) years following the Closing Date, which may be extended for another year at OHCA□s and□or FLIS□s discretion. The Independent Monitor will be responsible for monitoring the Applicants□compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to New Hospitals and their applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	
CON Condition 17: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of New Hospital on no less than a semi-annual basis to assess PMH□s modified Quality Assurance Performance Improvement (□QAPI□) program, and compliance with the Quality Commitment Letter. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	IM will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration□Leadership. IM will verify compliance with the □uality Assurance commitment Letter. IM will provide a written report to OHCA, and FLIS that summari□es the activities from the prior six month period along with any recommendations or observations
CON Condition 18: If, at any time within three (3) years following the Closing Date, the New Hospital□s Local Board agrees with PMH to change any of GWHN□s Post Closing Quality Practices described in the Quality Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and FLIS in writing within thirty (30) days of any such change going into effect. If the Independent Monitor disagrees with the change, OHCA may re□uire that a re□uest for modification be submitted and approved as re□uired by C.G.S. □4-18la to make the change. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*	IM will verify that PMH notifies OHCA and the Health Systems Branch in writing within 30 days of any change in the Seller Quality Programs with the exceptions i through iii as stated in condition 18.
CON Condition 19: For three (3) years following the Closing	IM will assure that Joint Board

Date, PMH shall hold a meeting of the New Hospital Board and the Local Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospital's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	Meetings occur twice annually followed by public meetings as required in Condition 19.
CON Condition 20: For three (3) years following the Closing Date, PMH shall allow for one (1) community representative to serve as a voting member of the Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representative shall be selected in consultation with the Mayor of Waterbury in order to ensure the appointment of an unbiased person who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will verify the New MMH and New RGH include 2 community representatives that are voting members of the local boards.
CON Condition 21: PMH, New GWHN and the New Hospital shall abide by all requirements of licensure that may be imposed by FLIS in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this condition to ensure that quality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 30-37*	IM will verify that all requirements of licensure are met.

User, OHCA

From: Cotto, Carmen
Sent: Monday, March 20, 2017 4:17 PM
To: colleen713.smith@gmail.com
Cc: User, OHCA; Martone, Kim; Roberts, Karen
Subject: RE: CON Compliance issue for Docket # 15-32017-486 Prospect GWHN

To: Colleen O Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http: nursingconsultingpartners.com

Hi Colleen,

This email is being sent to you as the Independent Monitor for the Certificate of Need (CON) Order issued under Docket Number 15-32017-486 for Prospect GWHN. Please be informed OHCA finds that the submission sent by Prospect GWHN on October 19, 2016 which included the *final execution copies of the Asset Purchase Agreement with schedules* is deficient in terms of the wording of Condition 3 of the CON Order, which states the following (yellow highlighting added):

3. Applicants shall notify OHCA in writing of the Closing Date of the Asset Purchase authori ed by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:

    a. the APA, including any and all schedules and exhibits; and

    b. Bylaws or similar governance documents for New GWHN.

The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. 1-210. If the Applicants redact materials in accordance with the previous sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

The material filed by Prospect GWHN on October 19, 2016 which is on the OHCA website at http: www.ct.gov dph lib dph ohca con_completed 2016 15_32017_486_compliance.pdf has a significant number of Schedules to the Asset Purchase Agreement, but there are numerous Schedules wherein Prospect GWHN merely lists Redacted per Conn. Gen. Stat. 1-210(b)(5). There is no filing of the re uired list to OHCA identifying the redacted material and why it is claimed to be exempt for public record purposes.

As Independent Monitor for this CON Docket Number, please have this compliance issue resolved at the earliest possible convenience.

Sincerely,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

User, OHCA

From: colleen713.smith@gmail.com
Sent: Tuesday, March 21, 2017 9:26 AM
To: Cotto, Carmen
Cc: User, OHCA; Martone, Kim; Roberts, Karen
Subject: Re: CON Compliance issue for Docket # 15-32017-486 Prospect GWHN

Dear Carmen,
Thank you for your email regarding Condition #3 of the CON for Prospect Waterbury. I will communicate your concerns today to the appropriate people at Waterbury and assure a timely response to your comments and correction of the deficient wording.
Best regards,
Colleen Smith
Independent Monitor
Sent from my iPad

On Mar 20, 2017, at 4:16 PM, Cotto, Carmen <Carmen.Cotto@ct.gov> wrote:

> To: Colleen O□Brien Smith MSN RN NEA-BC
> ***Nursing Consulting Partners, LLC***
> 690C9 S. Park View Court
> Franklin, WI 53132
> Phone: 203-245-1044
> Cell: 203-671-1348
> colleen713.smith@gmail.com
> http:□nursingconsultingpartners.com□
>
> Hi Colleen,
>
> This email is being sent to you as the Independent Monitor for the Certificate of Need (CON) Order issued under Docket Number 15-32017-486 for Prospect GWHN. Please be informed OHCA finds that the submission sent by Prospect GWHN on October 19, 2016 which included the □*final execution copies of the Asset Purchase Agreement with schedules* □ □is deficient in terms of the wording of Condition □3 of the CON Order, which states the following (yellow highlighting added):
>
> 3. Applicants shall notify OHCA in writing of the Closing Date of the Asset Purchase authori□ed by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:
>
> a. the APA, including any and all schedules and exhibits; and
>
> b. Bylaws or similar governance documents for New GWHN.
>
> The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. □1-210. If the Applicants redact materials in accordance with the

previous sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

The material filed by Prospect GWHN on October 19, 2016 which is on the OHCA website at http: www.ct.gov dph lib dph ohca con_completed 2016 15_32017_486_compliance.pdf has a significant number of Schedules to the Asset Purchase Agreement, but there are numerous Schedules wherein Prospect GWHN merely lists Redacted per Conn. Gen. Stat. 1-210(b)(5). There is no filing of the re uired list to OHCA identifying the redacted material and why it is claimed to be exempt for public record purposes.

As Independent Monitor for this CON Docket Number, please have this compliance issue resolved at the earliest possible convenience.

Sincerely,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

<image001.png>
www.ct.gov/dph

User, OHCA

From: Buckley, Katherine <kBuckley@wtbyhosp.org>
Sent: Thursday, March 30, 2017 7:12 PM
To: User, OHCA
Subject: Waterbury Docket # 15-32017-486, COndition #8
Attachments: OHCA Condition # 8 filing-Capital Investments.xlsx

Attached is Greater Waterbury Health Network's submission related to OHCA condition #8 of the Certificate of Need Final Decision.

Katherine Buckley
Finance Department

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Greater Waterbury Health Network
Docket # 15-32017-486
OHCA Condition #8 (page 1/2)

FY 16 Capital

(April 2016-Sept 2016)

Date	Vendor	Description	Dept	Reason	PO Number	Cost
April 7, 2016	Sorna Corp	Vertex System w/Starter Kit and Training	IS	Replacement of a broken and unrepairable CD burner which puts images to a CD for patients and physicians who need it.	374231B-002	$4,410.00
April 21, 2016	Remarket Medical	Refurbished Jackson Axis Surgery Table	OR	Replaced, broken unrepairable	378846	$42,050.00
May 27, 2016	Nova Biomedical Corp	Sensor Meter w/ Barcode Reader	Lab	Point of Care creatnine testing to enhance care of Stroke patients and avoid transfers out of WH	380409	$8,990.00
June 3, 2016	Medical Packaging Inc	2D Barcode Scanner/ Materials & Training	Pharmacy	Process improvement and operating cost reduction	380661	$18,320.40
June 7, 2016	Ultra Solutions, LLC	Philips Curved Array Transducer Probe	Radiology	Replace unrepairable, patient care	380762	$37,000.00
June 8, 2016	Tri Anim Health Serv.	Cruiser Cart, Vent, Mounts, Oxygen Hose	Respiratory	Transport vents, unrepairable, patient safety	380852	$27,806.08
June 21, 2016	Follett Corporation	Lab Upright Freezer & Shelves	Chemistry	Replace unrepairable, patient care	381399	$5,439.00
June 24, 2016	WB Mason Inc	LazBoy Recliner w/ Locking Back	Special Care	Replaced, patient safety	381556	$5,323.68
July 8, 2016	Health Stream Inc	Lectora Software & Training	Education	Healthstream License	271879B-002	$100.00
August 23, 2016	Intuitive Surgical Inc	Blanket Order for OR Service Fees (DIVINCI)	OR	Necessary to maintain Robot	372495B-003	$37,250.00
					Total	**$186,689.16**

User, OHCA

From: Cotto, Carmen
Sent: Wednesday, May 17, 2017 2:31 PM
To: colleen713.smith@gmail.com
Cc: User, OHCA; Roberts, Karen; Clarke, Ormand
Subject: RE: CON Compliance issue for Docket # 15-32017-486 Prospect GWHN_Condition #3

Hi Colleen,

Please provide us with the status of our request below for missing information related to Condition#3, Docket #15-32017-486 Prospect and GWHN merger.

Our records do not show the receipt of the information.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: colleen713.smith@gmail.com [mailto:colleen713.smith@gmail.com]
Sent: Tuesday, March 21, 2017 9:26 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: User, OHCA <OHCA@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Re: CON Compliance issue for Docket # 15-32017-486 Prospect GWHN

Dear Carmen,
Thank you for your email regarding Condition #3 of the CON for Prospect Waterbury. I will communicate your concerns today to the appropriate people at Waterbury and assure a timely response to your comments and correction of the deficient wording.
Best regards,
Colleen Smith

Independent Monitor
Sent from my iPad

On Mar 20, 2017, at 4:16 PM, Cotto, Carmen <Carmen.Cotto@ct.gov> wrote:

To: Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

Hi Colleen,

This email is being sent to you as the Independent Monitor for the Certificate of Need (CON) Order issued under Docket Number 15-32017-486 for Prospect GWHN. Please be informed OHCA finds that the submission sent by Prospect GWHN on October 19, 2016 which included the "*final execution copies of the Asset Purchase Agreement with schedules* " is deficient in terms of the wording of Condition 3 of the CON Order, which states the following (yellow highlighting added):

3. Applicants shall notify OHCA in writing of the Closing Date of the Asset Purchase authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:

    a. the APA, including any and all schedules and exhibits; and

    b. Bylaws or similar governance documents for New GWHN.

The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. 1-210. If the Applicants redact materials in accordance with the previous sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

The material filed by Prospect GWHN on October 19, 2016 which is on the OHCA website at http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32017_486_compliance.pdf has a significant number of Schedules to the Asset Purchase Agreement, but there are numerous Schedules wherein Prospect GWHN merely lists Redacted per Conn. Gen. Stat. 1-210(b)(5). There is no filing of the required list to OHCA identifying the redacted material and why it is claimed to be exempt for public record purposes.

As Independent Monitor for this CON Docket Number, please have this compliance issue resolved at the earliest possible convenience.

Sincerely,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

User, OHCA

From: Garrison De Lee (Legal Department) <Garrison.DeLee@prospectmedical.com>
Sent: Wednesday, May 24, 2017 6:56 PM
To: Cotto, Carmen; User, OHCA
Cc: 'colleen713.smith@gmail.com'; Schindel, Lester (lester.schindel@chartercare.org); Martone, Kim
Subject: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc.--OHCA Docket No. 15-32017-486-CON
Attachments: Prospect Waterbury List of Redacted Schedules and Reasons.xlsx; SPMHLEGAL17052415530.pdf

Dear Ms. Cotto:

Pursuant to Condition Number Three (3) in the final Decision for Docket NO. 15-32017-486, enclosed please find, as re□uested, a list of the redacted material for the Asset Purchase Agreement of Prospect Waterbury, Inc., which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes, together with a cover letter.

Garrison G. DeLee
Assistant General Counsel
Prospect Medical Holdings, Inc.
310-943-4500

NOTICE: This message and any attachment(s) may contain PRIVILEGED and CONFIDENTIAL information that is proprietary to Prospect Medical and is intended only for the use of the specific individual(s) to which it is addressed. It may contain Protected Health Information that is privileged and Confidential Protected Health Information may be used or disclosed in accordance with law and you may be subject to penalties under law for improper use or further disclosure of the Protected Health Information in this email. If you are not an intended recipient of this email, you are hereby notified that any unauthori□ed use, dissemination or copying of this email or the information contained in it or attached to it is strictly prohibited. If you have received this email in error, please delete it and immediately notify the person named above by reply email.

PROSPECT MEDICAL HOLDINGS, INC.

3415Sepulveda Boulevard
9th Floor
Los Angeles, CA 90034
Tel (310) 943-4500
Fax (310) 943-4501

May 24, 2017

VIA EMAIL
Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Transfer of Assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.

Project Title: Docket Number. 15-32017-486

Dear Ms. Cotto:

Pursuant to Condition Number Three (3) of the Order for the above referenced Certificate of Need Final Decision, please find the attached list of redacted material for the Asset Purchase Agreement for Prospect Waterbury, Inc., which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

If you have any questions, please contact the undersigned.

Sincerely,

Garrison G. DeLee
Assistant General Counsel

cc: Lester Schindel, Interim CEO, Prospect Waterbury, Inc.
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Healthcare Access
Colleen Smith, Nursing Consultant Partners, LLC

Re: Docket Number: 15-32017-486
Project Title: Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.

Condition Number Three (3)
List of schedules redacted and reason for redaction

Redacted Schedule	Description	Statutory Reference	Reason
Schedule 1.01(4)	Accounts Receivable	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 1.02(i)	Persons with "Seller's Knowledge"	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains files the disclosure of which would constitute an invasion of personal privacy
Schedule 2.01(b)	Leased Real Property	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.01(c)(i)	Description of Personal Property	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.01(c)(ii)	Leased Personal Property	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.01(f)	Assumed Contracts	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.01(m)	Prepaids	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.02(q)	Excluded Contracts	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.02(t)	Other Excluded Assets	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy
Schedule 2.03(d)	Capital Lease Obligations	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.03(g)	Assumed Employee Benefit Plans	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 3.02(c)	Exceptions to Absence of Conflicts	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.04	Investments and Third Party Rights	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.05(a)	Legal Compliance	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.05(b)	Corporate Integrity Agreements, Investigations and Complaints	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2) & (b)(5)]	Contains (a) files the disclosure of which would create an invasion of personal privacy; and (b) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (c) commercial or financial information given in confidence
Schedule 3.06	Financial Statements and Undisclosed Liabilities	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.9	Equipment Depreciation Schedule	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.11(b)	Real Property Disclosures	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.12	Environmental Claims	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.14	Insurance	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.17	Contracts Related to the Hospital Business	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.18	Consent, Assignment and Prohibition on Competition	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence

Schedule 3.19	Transactions with Affiliates	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.20(a)	Pending Labor Disputes	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.20(c)	Employment Matters	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.20(d)	Recently Terminated Employees	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.21(a)	Employee Benefit Plans	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.21(c)	Employee Benefit Plan Compliance and Issues	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2) & (b)(5)]	Contains (a) files the disclosure of which would create an invasion of personal privacy; and (b) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (c) commercial or financial information given in confidence
Schedule 3.22	Proceedings and Claims	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2) & (b)(5)]	Contains (a) files the disclosure of which would create an invasion of personal privacy; and (b) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (c) commercial or financial information given in confidence
Schedule 3.24	Material Medical Staff Disputes	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files and similar files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.28	Joint Ventures and Converted Ventures	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.29	Material Tangible Assets	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 8.06	Consent to Assignment of Assumed Contracts	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence

User, OHCA

From:	Buckley, Katherine <kBuckley@wtbyhosp.org>
Sent:	Wednesday, May 31, 2017 2:46 PM
To:	User, OHCA
Cc:	Martone, Kim; colleen713.smith@gmail.com; Garrison De Lee (Legal Department) (Garrison.DeLee@prospectmedical.com); Frank.Saidara@prospectmedical.com; Shin, Ellen (ellen.shin@prospectmedical.com); Roberts, Karen
Subject:	Docket Number 15-32017-486-CON
Attachments:	Docket Number 15-32017-486-CON OHCA Condition Numbers Eight Nine and Ten.pdf

Attached is the semi-annual submission related to condition numbers 8, 9, and 10 for the above referenced Certificate of Need Final Decision regarding the transfer of assets of Greater Waterbury Health Network to Prospect Medical Holdings, Inc.

Katherine Buckley-Finance Department
Waterbury Hospital

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WATERBURY HOSPITAL

May 31, 2017

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

RE: **Docket Number 15-32017-486**
Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Eight (8), Condition Number Nine (9), and Condition Number Ten (10) regarding the transfer of assets of Greater Waterbury Health Network (GWHN) to Prospect Medical Holdings, Inc (PMH). Please note that the transaction closed on October 1, 2016. ("Closing Date").

Condition Number Eight (8) requires submission of a report ("Capital Investment Report") on the capital investments PMH has made in the New GWHN. Exhibit A is a listing of the paid capital expenditures made between Oct 2016 and March 2017, along with a description of the projects and justifications for the expenses. Exhibit B is a listing of the estimated timeframe for rollout of approved capital projects as of May 2017.

Condition Number Nine (9) requires that PMH provide a report for New GWHN and New Waterbury Hospital with information regarding the following:

a. The cost saving totals achieved in the following Operating Expense Categories for New GWHN and New Hospital: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business expenses, and other Operating Expenses. The categories shall be consistent with the major operating expense categories which are in use at the time of reporting in the OHCA Hospital reporting

System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. The major cost savings achieved for each expense category for the semi-annual period: and
2. The effect of cost savings on the clinical quality of care.

b. A Consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New GWHN and New Waterbury Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

For Condition Number Nine (9.a), please see Exhibit C which shows the expenses by category using the form of HRS Report 175 which will serve as the baseline for comparison to report any cost savings achieved under PMH's ownership when the next filing for this condition is due on November 30, 2017.

For Condition Number Nine (9.b), please see Exhibit D which includes the Balance Sheet, Statement of Operations, and Statement of Cash Flows for New GWHN and New Waterbury Hospital using the form of HRS reports 100/150 and 300/350.

Condition Number Ten (10) requires that on a semi-annual basis, PMH provide a report of specific financial measurements/indicators showing current month and year to date data and comparable prior period year to date data for New GWHN and New Waterbury Hospital. Exhibit E provides this requested detail for the period of October 1, 2016 through March 31, 2017. The referenced exhibit provides the required current month and year to date measurements. These measurements will serve as a basis for comparison measurements for the next report which will be filed by November 30, 2017.

If you have any questions or need anything further, please feel free to call me at 203-573-7280.

Sincerely,

Paul Golino
Senior Vice President/Chief Financial Officer

Attachments:

Exhibit A-Condition Number Eight (8)-Capital Investment Report
Exhibit B-Condition Number Eight (8)-Capital purchases that are currently approved
Exhibit C-Condition Number Nine (9.a)-Expenses by Category
Exhibit D-Condition Number Nine (9.b)-Consolidated Balance Sheets, Statement of Operations, and Statements of Cash Flows for New GWHN and New Waterbury Hospital
Exhibit E-Condition Number Ten (10)-Current month and year to date measurements

cc: Kimberly R. Martone, Director of Operations, Office of Health Care Access, CT Department of Health
Karen Roberts, Principal Health Care Analyst, Office of Health Care Access, CT Department of Public Health
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc

Exhibit A

Prospect Waterbury, Inc
Capital Investment Report
Paid Capital-Oct 2016 to Mar 2017

Complete Yes

Fiscal Year	Fiscal Quarter	Date Sub.	Item Description	Justification	Cost
2017	Quarter 1	10/31/2016	Paving of parking lots	Many pot holes beyond repair	$ 267,927.56
2017	Quarter 1	11/21/2016	Ultrasound ECHO	Expand services to patients with additional technology of STRAIN & 4D	$ 92,518.05
2017	Quarter 1	11/21/2016	X-Ray/Chase Clinic	Expand services to our patients for a full service experience in our clinic	$ 112,613.85
2017	Quarter 1	11/28/2016	Single Site Instruments Davinci Robot	Patient preference for surgical access 1 site versus 3 sites	$ 24,819.63
2017	Quarter 1	11/30/2016	Respiratory COW Batteries	Upgraded to Lithium batteries	$ 14,674.58
2017	Quarter 1	11/30/2016	TROY Check Software Upgrade	Mandatory upgrade for paychecks software sunsetting	$ 8,250.63
2017	Quarter 1	12/27/2016	BH - 6 beds	Replacement of current older beds	$ 13,152.82
2017	Quarter 2	1/12/2017	Wilson Frame (Neurosurgery)	Replacement upgrade	$ 5,295.10
2017	Quarter 2	1/12/2017	Wipe Test / Well Counter	Updated technology	$ 4,350.00
2017	Quarter 2	1/23/2017	Shoulder Positioner	Replacement upgrade	$ 5,424.29
2017	Quarter 2	1/24/2017	Bloodbank Refrigerator - ER	Enhance response times for trauma patients providing resources closet to critical patients	$ 8,000.00
2017	Quarter 2	2/28/2017	Resident Furniture	Updated furniture for the on call rooms	$ 4,121.11
2017	Quarter 2	3/20/2017	OR Power Tools	Large Bone power tools replacement total joints/spine surgery	$ 287,233.69
2017	Quarter 2	3/23/2017	Mini C-Arm	Replacement & upgrade of current equipment upper/lower extremity surgery	$ 70,687.50
2017	Quarter 2	3/23/2017	Compllement drives for necessary disk space	IT upgrade	$ 38,394.96
2017	Quarter 2	3/23/2017	Computer Medical Carts	Computers on wheels for the nursing floors	$ 138,281.59
2017	Quarter 2	3/23/2017	Lateral positioner for hip surgeries	Equipment for OR surgical cases	$ 2,373.25
2017	Quarter 2	3/24/2017	Lumenis Laser - Urology	New Laser for urology services	$ 133,700.00
2017	Quarter 2	3/24/2017	diVinci Software Upgrade	Necessary software upgrade	$ 81,562.50
2017	Quarter 2	3/24/2017	diVinci Table	Trumpf bed/table to use with the diVinci robot	$ 97,748.85
2017	Quarter 2	3/24/2017	Medical Basket Carts	Medical basket carts for patient care assistants on nursing floors	$ 310,746.31
2017	Quarter 2	3/30/2017	2 Anesthesia Machines	New machines replacements for the OR	$ 107,287.31
2017	Quarter 2	3/30/2017	OR Ultrasound System	New ultasound machine for OR	$ 132,501.00
2017	Quarter 2	3/30/2017	Remaining Power Tools	Small Bone power tools replacement	$ 483,703.00
2017	Quarter 2	3/30/2017	Fracture Table	Replacement & new fracture table	$ 84,254.64
2017	Quarter 2	3/30/2017	Medication Refrigerator	Replacement & new refrigerator	$ 10,681.01
2017	Quarter 2	3/31/2017	Ultraound Machine	New equipment for surgical services	$ 80,322.75
2017	Quarter 2	3/31/2017	Vascular Probe	New probe for use with ultrasound machine	$ 6,851.25
Grand Total					**$ 2,627,477.23**

Exhibit B

WATERBURY HOSPITAL

As of 5/23/17/2017

Capital Needs Approved-FY2017

Description
LS = Life Safety
ROI = Return on Investment
S = Spash
E = Everything Else

QUARTER 1	Amount	Desc.	Year		Quarter	Commentary
ED Renovation	TBD	ROI	1	1	1st Quarter	LOI Architech selected $135K
Parking lot repaving - lot 5A - Doctors	$127,206	S	1	1	1st Quarter	Completed
2 OR lights	$250,000	S	1	1	1st Quarter	Pilot ongoing
Ultrasound ECHO	$81,470	ROI	1	1	1st Quarter	Ordered & Arrived
X-Ray/Chase Clinic	$113,443	ROI	1	1	1st Quarter	Ordered & Arrived
Cart Washer	$157,000	LS	1	1	1st Quarter	Ordered & Arrived
BH - 6 beds	$12,000	E	1	1	1st Quarter	Ordered & Arrived
2 Anesthesia Machines	TBD	LS	1	1	1st Quarter	Ordered & Arrived
Single Site Instruments Davinci Robot	$25,000	ROI	1	1	1st Quarter	Ordered & Arrived
Signage	$100,000	S	1	1	1st Quarter	Ordered & Arrived
Q1 TOTAL:	**$866,119**					
QUARTER 2:						
1 Fracture Table	$100,000	E	1	2	2nd Quarter	Ordered & Arrived
Med cart replacements	$150,000	S	1	2	2nd Quarter	Ordered & Arrived
Merriman Hall Security	$58,000	LS	1	2	2nd Quarter	Ordered & Arrived
Orthopedic Power Equipment	$200,000	ROI	1	2	2nd Quarter	Ordered & Arrived
Blood Bank Refrigerator	$6,000	LS	1	2	2nd Quarter	Ordered & Arrived
Trumpf Bed/Software	$150,000	ROI	1	2	2nd Quarter	Ordered & Arrived
4 Ceiling Lifts	$40,000	LS	1	2	2nd Quarter	Quotes pending
Q2 TOTAL:	**$704,000**					
QUARTER 3:						
Parking lot repaving - lot 1 - Patients	TBD	S	1	3	3rd Quarter	
Parking lot repaving - lot 2 - Employees	$135,729	S	1	3	3rd Quarter	
Parking lot repaving - lot 3 - Patients	$146,461	S	1	3	3rd Quarter	
Parking lot repaving - lot 4 - Employees	$130,994	S	1	3	3rd Quarter	
Parking lot repaving - lot 5 - Employees	$568,166	S	1	3	3rd Quarter	
Q3 TOTAL:	**$981,350**					
QUARTER 4:						
Nuclear Med	$450,000	ROI	1	1,2,3,4	1st - 4th Quarter	Quotes pending
Digital radiology	$450,000	ROI	2		2nd - 4th Quarter	Quotes pending
Mobile digital radiology	$450,000	ROI	2		3rd - 4th Quarter	Quotes pending
Cardiac stress	$60,000	E	2		4th Quarter	
Isolettes/Warmers	$320,000	E	2		4th Quarter	Qoutes pending CER submission
OR Tables	$500,000	E	2		4th Quarter	Ordered
Med Cart Replacements	$150,000	S	2+		4th Quarter	Ordered & Arrived
EKG	$550,000	E	2+		4th Quarter	Quotes pending
Defibrillators	$240,000	LS	2+		4th Quarter	Quotes pending
Bed Replacements	$360,000	E	2+		4th Quarter	Quotes pending
Maternity department upgrade	$1,500,000	S	2+		4th Quarter	Nurse Call/Flat Screeen TVs/Paint/Carpet
Q4 TOTAL:	**$5,030,000**					
GRAND TOTAL:	**$7,581,469**					

Exhibit C

Prospect Waterbury Hospital and Prospect GWHN
Report 175 Operating Expenses by Category
October 2016 to March 2017

Line	Category	New Waterbury Hospital	New GWHN
A	Salary and Wages	$41,248,306	$64,753,541
B	Fringe Benefits	$12,496,525	$16,137,692
C	Contracted Labor Fees	$4,706,266	$6,013,427
D	Medical Supplies and Pharmaceutical Cost	$15,310,702	$16,359,131
E	Depreciation and Amortization	$3,079,500	$3,477,535
F	Bad Debts	$0	$0
G	Interest Expense	$633,140	$634,280
H	Malpractice Insurance Cost	$2,682,654	$3,363,317
I	utilites	$1,665,302	$1,982,877
J	Business Expenses	$17,955,483	$22,050,800
K	Other Operating Expenses	$3,089,328	$3,089,328
	Total Operating Expenses-All Expense Categories	**$102,867,206**	**$137,861,928**

EXHIBIT D

WATERBURY HOSPITAL

SIX MONTH ACTUAL FILING - AS OF 3/31/17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	
LINE	DESCRIPTION	
I.	ASSETS	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	($89,372)
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$31,221,747
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$0
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$3,242,867
8	Prepaid Expenses	$2,268,970
9	Other Current Assets	$388,299
	Total Current Assets	**$37,032,511**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$11,814,597
7	Other Noncurrent Assets	$165,565
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$276,040,181
2	Less: Accumulated Depreciation	$252,153,026
	Property, Plant and Equipment, Net	**$23,887,155**
3	Construction in Progress	$9,803
	Total Net Fixed Assets	**$23,896,958**
	Total Assets	**$72,909,631**

EXHIBIT D

WATERBURY HOSPITAL

SIX MONTH ACTUAL FILING - AS OF 3/31/17

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	
LINE	DESCRIPTION	
II.	LIABILITIES AND NET ASSETS	
A.	Current Liabilities:	
1	Accounts Payable and Accrued Expenses	$20,348,557
2	Salaries, Wages and Payroll Taxes	$2,934,125
3	Due To Third Party Payers	$3,204,387
4	Due To Affiliates	$5,053,769
5	Current Portion of Long Term Debt	$0
6	Current Portion of Notes Payable	$756,806
7	Other Current Liabilities	$0
	Total Current Liabilities	**$32,297,644**
B.	Long Term Debt:	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$1,515,650
	Total Long Term Debt	**$1,515,650**
3	Accrued Pension Liability	$0
4	Other Long Term Liabilities	$13,734,292
	Total Long Term Liabilities	**$15,249,942**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	Net Assets:	
1	Unrestricted Net Assets or Equity	$25,362,045
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**$25,362,045**
	Total Liabilities and Net Assets	**$72,909,631**

EXHIBIT D

WATERBURY HOSPITAL

OCTOBER 1, 2016 THROUGH MARCH 31, 2017 FILING

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	
LINE	DESCRIPTION	
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$448,713,267
2	Less: Allowances	$333,827,114
3	Less: Charity Care	$3,686,190
4	Less: Other Deductions	$6,210,700
	Total Net Patient Revenue	$104,989,263
5	Provision for Bad Debts	($177,507)
	Net Patient Service Revenue less provision for bad debts	$105,166,790
6	Other Operating Revenue	$2,056,285
7	Net Assets Released from Restrictions	$1,306,157
	Total Operating Revenue	$108,529,232
B.	**Operating Expenses:**	
1	Salaries and Wages	$41,248,306
2	Fringe Benefits	$12,495,525
3	Physicians Fees	$3,868,200
4	Supplies and Drugs	$15,310,702
5	Depreciation and Amortization	$3,079,500
6	Bad Debts	$0
7	Interest Expense	$633,140
8	Malpractice Insurance Cost	$2,682,654
9	Other Operating Expenses	$23,548,179
	Total Operating Expenses	$102,867,206
	Income/(Loss) From Operations	$5,662,026
C.	**Non-Operating Revenue:**	
1	Income from Investments	$0
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	$0
	Total Non-Operating Revenue	$0
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	$5,662,026
	Other Adjustments:	
	Unrealized Gains/(Losses)	$0
	All Other Adjustments	$0
	Total Other Adjustments	$0
	Excess/(Deficiency) of Revenue Over Expenses	$5,662,026
	Principal Payments	$1,348,691

EXHIBIT D

GREATER WATERBURY HEALTH NETWORK

FISCAL YEAR 2017 - as of 3/31/17

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET

(1)	(2)	
LINE	DESCRIPTION	
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$4,988,736
2	Short Term Investments	$565,361
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$40,487,277
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$0
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$3,539,911
8	Prepaid Expenses	$3,013,814
9	Other Current Assets	$1,422,984
	Total Current Assets	**$54,018,083**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$11,906,636
7	Other Noncurrent Assets	$229,457
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$291,326,883
2	Less: Accumulated Depreciation	$263,828,878
	Property, Plant and Equipment, Net	**$27,498,005**
3	Construction in Progress	$9,803
	Total Net Fixed Assets	**$27,507,808**
	Total Assets	**$93,661,984**

EXHIBIT D

GREATER WATERBURY HEALTH NETWORK

FISCAL YEAR 2017 - as of 3/31/17

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET

(1)	(2)	
LINE	DESCRIPTION	
II.	LIABILITIES AND NET ASSETS	
A.	Current Liabilities:	
1	Accounts Payable and Accrued Expenses	$22,448,070
2	Salaries, Wages and Payroll Taxes	$4,959,701
3	Due To Third Party Payers	$3,504,387
4	Due To Affiliates	$9,579,332
5	Current Portion of Long Term Debt	$21,571
6	Current Portion of Notes Payable	$770,497
7	Other Current Liabilities	$100,653
	Total Current Liabilities	**$41,384,211**
B.	Long Term Debt:	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$1,518,098
	Total Long Term Debt	**$1,518,098**
3	Accrued Pension Liability	$0
4	Other Long Term Liabilities	$14,418,825
	Total Long Term Liabilities	**$15,936,923**
5	Interest in Net Assets of Affiliates or Joint Ventures	$2,584,538
C.	Net Assets:	
1	Unrestricted Net Assets or Equity	$33,756,312
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**$33,756,312**
	Total Liabilities and Net Assets	**$93,661,984**

EXHIBIT D		
GREATER WATERBURY HEALTH NETWORK		
OCTOBER 1, 2016 THROUGH MARCH 31, 2017 FILING		
REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	
LINE	DESCRIPTION	
A.	Operating Revenue:	
1	Total Gross Patient Revenue	$499,814,837
2	Less: Allowances	$359,247,628
3	Less: Charity Care	$3,686,190
4	Less: Other Deductions	$6,210,700
	Total Net Patient Revenue	$130,670,319
5	Provision for Bad Debts	$184,334
	Net Patient Service Revenue less provision for bad debts	$130,485,985
6	Other Operating Revenue	$5,445,486
7	Net Assets Released from Restrictions	$1,306,157
	Total Operating Revenue	$137,237,628
		$0
B.	**Operating Expenses:**	$0
1	Salaries and Wages	$64,753,541
2	Fringe Benefits	$19,137,692
3	Physicians Fees	$4,438,933
4	Supplies and Drugs	$16,359,131
5	Depreciation and Amortization	$3,477,535
6	Bad Debts	$0
7	Interest Expense	$634,280
8	Malpractice Insurance Cost	$3,363,317
9	Other Operating Expenses	$28,697,499
	Total Operating Expenses	$137,861,928
		$0
	Income/(Loss) From Operations	($624,300)
		$0
C.	**Non-Operating Revenue:**	$0
1	Income from Investments	$0
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	($307,269)
	Total Non-Operating Revenue	($307,269)
		$0
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	($931,569)
		$0
	Other Adjustments:	$0
	Unrealized Gains/(Losses)	$0
	All Other Adjustments	$0
	Total Other Adjustments	$0
		$0
	Excess/(Deficiency) of Revenue Over Expenses	($931,569)

EXHIBIT D

Waterbury Hospital
Statement of Cash Flows
3/31/17

	Y-T-D March 2017
Net Income/(Loss)	5,662,026
Adjustments to reconcile net income/(loss) to net cash (used in)/provided by operating activities and nonoperating revenues:	
Provision for bad debt	(177,507)
Depreciation and amortization	3,079,500
	8,564,019
Changes in operating working capital other than cash and cash equivalents:	
Patient accounts receivable (net)	(10,642,271)
Grants and other receivables	1,147,371
Inventory of supplies	(79,940)
Prepaid insurance and other expenses	(1,086,932)
Accounts payable and accrued expenses	3,220,751
Salaries, wages, payroll taxes and amounts withheld from employees	47,860
Due to restricted funds	215,492
Other noncurrent liabilities	(174,979)
Due to 3rd party reimbursement agencies	3,204,387
	(4,148,261)
Net cash (used in)/provided by operating activities and nonoperating gains	4,415,758
Investing activities:	
(Increase)/decrease in due from affiliates	(5,220,025)
Decrease/(increase) in other assets	(167,470)
Additions to property, plant and equipment	(1,098,370)
Net cash (used by)/provided by investing activities	(6,485,865)
Financing activities:	
Proceeds from issuance of debt	0
Principal payments on debt obligations	(1,348,691)
Net cash (used in)/provided by financing activities	(1,348,691)
Net increase/(decrease) in cash and cash equivalents	(3,418,798)
Cash and cash equivalents at beginning of period	3,329,426
Cash and cash equivalents at end of period	(89,372)

EXHIBIT D

Greater Waterbury Health Network
Statement of Cash Flows
3/31/17

	Y-T-D March 2017
Net Income/(Loss)	(931,569)
Adjustments to reconcile net income/(loss) to net cash (used in)/provided by operating activities and nonoperating revenues:	
Provision for bad debt	184,334
Depreciation and amortization	3,477,535
	2,730,300
Changes in operating working capital other than cash and cash equivalents:	
Patient accounts receivable (net)	(13,715,926)
Grants and other receivables	348,727
Inventory of supplies	(79,940)
Prepaid insurance and other expenses	(1,288,798)
Accounts payable and accrued expenses	4,210,251
Salaries, wages, payroll taxes and amounts withheld from employees	(319,906)
Due to restricted funds	215,492
Other noncurrent liabilities	18,130
Due to 3rd party reimbursement agencies	3,204,387
	(7,407,583)
Net cash (used in)/provided by operating activities and nonoperating gains	(4,677,283)
Investing activities:	
(Increase)/decrease in due from affiliates	5,640,376
Decrease/(increase) in other assets	(231,170)
Additions to property, plant and equipment	(1,267,934)
Net cash (used by)/provided by investing activities	4,141,272
Financing activities:	
Proceeds from issuance of debt	0
Principal payments on debt obligations	(1,335,587)
Net cash (used in)/provided by financing activities	(1,335,587)
Net increase/(decrease) in cash and cash equivalents	(1,871,598)
Cash and cash equivalents at beginning of period	7,425,695
Cash and cash equivalents at end of period	5,554,097

EXHIBIT E

Month of March, 2016
Hospital Only

Monthly Financial Measurement/Indicators

		Definitions	Calculation Used
A. Operating Performance			
Operating Margin	**12.01%**		
Non-Operating Margin	**12.86%**		
Total Margin	**12.90%**		
Bad Debt as % Gross Revenue	**1.69%**		
B. Liquidity			
Current Ratio	**1.22**		
Days Cash on Hand	**22.19**		
Days in Net Accounts Receivables	**46.13**		
Average Payment Period	**66.71**		
C. Leverage and Capital Structure			
Long-term Debt to Equity	**(2.6502)**	Ratio = Long-term debt / (Preferred stock + Common stock)	Ratio = Long-term debt / (Net Assets)
Long-term Debt to Capitalization	**1.6060**	Ratio = Long-term debt / (Long-term debt + Preferred stock + Common stock	Ratio = Long-term debt / (Long-term debt + Net Assets)
Unrestricted Cash to Debt	**0.4709**	Unrestricted Cash/Total Debt	Cash & Cash Equivalents/Total Debt (Current Portion and Non-Current Portion)
Times Interest Earned Ratio	**N/A**	company's earnings before interest and taxes by the total interest payable on its debts	N/A since there is no interest payable at the balance sheet date
Debt Service Coverage Ratio	**(3.71)**		
Equity Financing Ratio	**(8.86)**	calculated by dividing the company's total liabilities by stockholders' equity	calculated by dividing the company's total liabilities by net assets
D. Additional Statistics			
Income from Operations	**3,121,149**		EBITDA (Income from Operations plus Depreciation, Interest, and Amortization)
Revenue Over/(Under) Expense	**2,681,454**		Net Income/(Loss)
Patient Cash Collected	**18,661,051**		
Cash and Cash Equivalents	**13,971,573**		
Net Working Capital	**8,743,448**		
Free Cash Flow	**13,832,250**		
Unrestricted Assets/Retained Earnings	**(10,514,041)**		
Credit Ratings (S&P, FITCH and Moody's)	Not Applicable		

Month of March, 2016
Hospital and Affiliates

Monthly Financial Measurement/Indicators

A. Operating Performance	
Operating Margin	**6.51%**
Non-Operating Margin	**7.20%**
Total Margin	**7.46%**
Bad Debt as % Gross Revenue	**1.62%**
B. Liquidity	
Current Ratio	**1.44**
Days Cash on Hand	**44.59**
Days in Net Accounts Receivables	**42.94**
Average Payment Period	**57.98**
C. Leverage and Capital Structure	
Long-term Debt to Equity	**(2.3581)**
Long-term Debt to Capitalization	**1.7363**
Unrestricted Cash to Debt	**0.7077**
Times Interest Earned Ratio	**N/A**
Debt Service Coverage Ratio	**2.38**
Equity Financing Ratio	**(9.61)**
D. Additional Statistics	
Income from Operations	**2,357,690**
Revenue Over/(Under) Expense	**1,911,193**
Patient Cash Collected	**22,925,438**
Cash and Cash Equivalents	**21,008,968**
Net Working Capital	**19,640,963**
Free Cash Flow	**20,829,213**
Unrestricted Assets/Retained Earnings	**(11,816,346)**
Credit Ratings (S&P, FITCH and Moody's)	Not Applicable

EXHIBIT E

Month of March, 2017
Hospital Only

Monthly Financial Measurement/Indicators

		Definitions	Calculation Used
A. Operating Performance			
Operating Margin	**6.14%**		
Non-Operating Margin	**6.14%**		
Total Margin	**6.14%**		
Bad Debt as % Gross Revenue	**0.11%**		
B. Liquidity			
Current Ratio	**1.17**		
Days Cash on Hand	**(0.16)**		
Days in Net Accounts Receivables	**50.32**		
Average Payment Period	**50.01**		
C. Leverage and Capital Structure			
Long-term Debt to Equity	**0.0598**	Ratio = Long-term debt / (Preferred stock + Common stock)	Ratio = Long-term debt / (Net Assets)
Long-term Debt to Capitalization	**0.0564**	Ratio = Long-term debt / (Long-term debt + Preferred stock + Common stock	Ratio = Long-term debt / (Long-term debt + Net Assets)
Unrestricted Cash to Debt	**(0.0393)**	Unrestricted Cash/Total Debt	Cash & Cash Equivalents/Total Debt (Current Portion and Non-Current Portion)
Times Interest Earned Ratio	**N/A**	company's earnings before interest and taxes by the total interest payable on its debts	N/A since there is no interest payable at the balance sheet date
Debt Service Coverage Ratio	**N/A**		
Equity Financing Ratio	**1.68**	calculated by dividing the company's total liabilities by stockholders' equity	calculated by dividing the company's total liabilities by net assets
D. Additional Statistics			
Income from Operations	**2,229,400**		EBITDA (Income from Operations plus Depreciation, Interest, and Amortization)
Revenue Over/(Under) Expense	**1,140,870**		Net Income/(Loss)
Patient Cash Collected	**20,849,371**		
Cash and Cash Equivalents	**(89,372)**		
Net Working Capital	**4,734,867**		
Free Cash Flow	**(210,154)**		
Unrestricted Assets/Retained Earnings	**25,362,045**		
Credit Ratings (S&P, FITCH and Moody's)	Not Applicable		

Month of March, 2017
Hospital and Affiliates

Monthly Financial Measurement/Indicators

A. Operating Performance	
Operating Margin	**0.15%**
Non-Operating Margin	**0.15%**
Total Margin	**0.15%**
Bad Debt as % Gross Revenue	**0.16%**
B. Liquidity	
Current Ratio	**1.40**
Days Cash on Hand	**7.56**
Days in Net Accounts Receivables	**54.77**
Average Payment Period	**43.89**
C. Leverage and Capital Structure	
Long-term Debt to Equity	**0.0450**
Long-term Debt to Capitalization	**0.0430**
Unrestricted Cash to Debt	**2.4042**
Times Interest Earned Ratio	**N/A**
Debt Service Coverage Ratio	**N/A**
Equity Financing Ratio	**1.41**
D. Additional Statistics	
Income from Operations	**1,183,330**
Revenue Over/(Under) Expense	**35,595**
Patient Cash Collected	**25,113,758**
Cash and Cash Equivalents	**5,554,097**
Net Working Capital	**12,633,872**
Free Cash Flow	**5,554,097**
Unrestricted Assets/Retained Earnings	**33,756,312**
Credit Ratings (S&P, FITCH and Moody's)	Not Applicable

EXHIBIT E

YTD March, 2016
Hospital Only

Monthly Financial Measurement/Indicators

		Definitions	Calculation Used
A. Operating Performance			
Operating Margin	**2.66%**		
Non-Operating Margin	**5.20%**		
Total Margin	**5.20%**		
Bad Debt as % Gross Revenue	**0.56%**		
B. Liquidity			
Current Ratio	**1.22**		
Days Cash on Hand	**22.19**		
Days in Net Accounts Receivables	**46.13**		
Average Payment Period	**66.71**		
C. Leverage and Capital Structure			
Long-term Debt to Equity	**(2.6502)**	Ratio = Long-term debt / (Preferred stock + Common stock)	Ratio = Long-term debt / (Net Assets)
Long-term Debt to Capitalization	**1.6060**	Ratio = Long-term debt / (Long-term debt + Preferred stock + Common stock	Ratio = Long-term debt / (Long-term debt + Net Assets)
Unrestricted Cash to Debt	**0.4709**	Unrestricted Cash/Total Debt	Cash & Cash Equivalents/Total Debt (Current Portion and Non-Current Portion)
Times Interest Earned Ratio	**N/A**	company's earnings before interest and taxes by the total interest payable on its debts	N/A since there is no interest payable at the balance sheet date
Debt Service Coverage Ratio	**(3.71)**		
Equity Financing Ratio	**(8.86)**	calculated by dividing the company's total liabilities by stockholders' equity	calculated by dividing the company's total liabilities by net assets
D. Additional Statistics			
Income from Operations	**6,706,634**		EBITDA (Income from Operations plus Depreciation, Interest, and Amortization)
Revenue Over/(Under) Expense	**5,623,041**		Net Income/(Loss)
Patient Cash Collected	**108,859,393**		
Cash and Cash Equivalents	**13,971,573**		
Net Working Capital	**8,743,448**		
Free Cash Flow	**13,054,288**		
Unrestricted Assets/Retained Earnings	**(10,514,041)**		
Credit Ratings (S&P, FITCH and Moody's)	Not Applicable		

YTD March, 2016
Hospital and Affiliates

Monthly Financial Measurement/Indicators

A. Operating Performance	
Operating Margin	**-1.72%**
Non-Operating Margin	**0.31%**
Total Margin	**0.34%**
Bad Debt as % Gross Revenue	**0.59%**
B. Liquidity	
Current Ratio	**1.44**
Days Cash on Hand	**44.59**
Days in Net Accounts Receivables	**42.94**
Average Payment Period	**57.98**
C. Leverage and Capital Structure	
Long-term Debt to Equity	**(2.3581)**
Long-term Debt to Capitalization	**1.7363**
Unrestricted Cash to Debt	**0.7077**
Times Interest Earned Ratio	**N/A**
Debt Service Coverage Ratio	**2.38**
Equity Financing Ratio	**(9.61)**
D. Additional Statistics	
Income from Operations	**1,898,952**
Revenue Over/(Under) Expense	**460,751**
Patient Cash Collected	**129,058,915**
Cash and Cash Equivalents	**21,008,968**
Net Working Capital	**19,640,963**
Free Cash Flow	**19,976,137**
Unrestricted Assets/Retained Earnings	**(11,816,346)**
Credit Ratings (S&P, FITCH and Moody's)	**Not Applicable**

EXHIBIT E

YTD March, 2017
Hospital Only

Monthly Financial Measurement/Indicators

		Definitions	Calculation Used
A. Operating Performance			
Operating Margin	5.22%		
Non-Operating Margin	5.22%		
Total Margin	5.22%		
Bad Debt as % Gross Revenue	0.19%		
B. Liquidity			
Current Ratio	1.17		
Days Cash on Hand	(0.16)		
Days in Net Accounts Receivables	50.32		
Average Payment Period	50.01		
C. Leverage and Capital Structure			
Long-term Debt to Equity	0.0598	Ratio = Long-term debt / (Preferred stock + Common stock)	Ratio = Long-term debt / (Net Assets)
Long-term Debt to Capitalization	0.0564	Ratio = Long-term debt / (Long-term debt + Preferred stock + Common stock	Ratio = Long-term debt / (Long-term debt + Net Assets)
Unrestricted Cash to Debt	(0.0393)	Unrestricted Cash/Total Debt	Cash & Cash Equivalents/Total Debt (Current Portion and Non-Current Portion)
Times Interest Earned Ratio	N/A	company's earnings before interest and taxes by the total interest payable on its de	N/A since there is no interest payable at the balance sheet date
Debt Service Coverage Ratio	N/A		
Equity Financing Ratio	1.68	calculated by dividing the company's total liabilities by stockholders' equity	calculated by dividing the company's total liabilities by net assets
D. Additional Statistics			
Income from Operations	9,374,566		EBITDA (Income from Operations plus Depreciation, Interest, and Amortization)
Revenue Over/(Under) Expense	5,562,026		Net Income/(Loss)
Patient Cash Collected	100,753,617		
Cash and Cash Equivalents	(69,372)		
Net Working Capital	4,734,867		
Free Cash Flow	(1,041,253)		
Unrestricted Assets/Retained Earnings	25,362,045		
Credit Ratings (S&P, FITCH and Moody's)	Not Applicable		

YTD March, 2017
Hospital and Affiliates

Monthly Financial Measurement/Indicators

A. Operating Performance	
Operating Margin	-0.68%
Non-Operating Margin	-0.68%
Total Margin	-0.68%
Bad Debt as % Gross Revenue	0.24%
B. Liquidity	
Current Ratio	1.40
Days Cash on Hand	7.56
Days in Net Accounts Receivables	54.77
Average Payment Period	43.89
C. Leverage and Capital Structure	
Long-term Debt to Equity	0.0450
Long-term Debt to Capitalization	0.0430
Unrestricted Cash to Debt	2.4042
Times Interest Earned Ratio	N/A
Debt Service Coverage Ratio	N/A
Equity Financing Ratio	1.41
D. Additional Statistics	
Income from Operations	3,132,463
Revenue Over/(Under) Expense	(931,690)
Patient Cash Collected	120,953,139
Cash and Cash Equivalents	5,554,097
Net Working Capital	12,633,872
Free Cash Flow	5,375,536
Unrestricted Assets/Retained Earnings	33,756,312
Credit Ratings (S&P, FITCH and Moody's)	Not Applicable

User, OHCA

From: Buckley, Katherine <kBuckley@wtbyhosp.org>
Sent: Wednesday, May 31, 2017 2:48 PM
To: User, OHCA
Cc: Martone, Kim; colleen713.smith@gmail.com; Garrison De Lee (Legal Department) (Garrison.DeLee@prospectmedical.com); Frank.Saidara@prospectmedical.com; Shin, Ellen (ellen.shin@prospectmedical.com)
Subject: Docket Number 15-32017-486-CON
Attachments: Docket Number 15-32017-486-CON OHCA Condition Number Nineteen.pdf

Attached is the semi-annual submission related to condition number 19 for the above referenced Certificate of Need Final Decision regarding the transfer of assets of Greater Waterbury Health Network to Prospect Medical Holdings, Inc.

Katherine Buckley-Finance Department
Waterbury Hospital

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WATERBURY HOSPITAL

May 31, 2017

Ms. Karen Roberts
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

RE: **Docket Number: 15-32017-486**
Transfer of assets of Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc.

Dear Ms. Roberts:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Nineteen (19) regarding the transfer of assets of Greater Waterbury Health Network (GWHN) to Prospect Medical Holdings, Inc (PMH).

Condition Number Nineteen (19) requires that PMH will hold a joint meeting of the New Waterbury Hospital Board and Local Board at least twice annually (for 3 years after closing). Such Joint Board Meetings must be followed by meeting for the public, where the public is informed of the New Waterbury Hospital activities and given the opportunity to ask questions and make comments.

A Joint Meeting of the Board of Directors for Prospect Waterbury, Inc. and the Local Board for Prospect Waterbury, Inc was held on May 11, 2017. That meeting was followed by a meeting on the same date for the Waterbury community where information about the hospital's activities was shared and the public was encouraged to ask questions and provide comments. This meeting was advertised in the Republican American newspaper on May 4, 2017 and May 8, 2017.

If you have any questions or need anything further, please feel free to call me at 203-573-7280.

Sincerely,

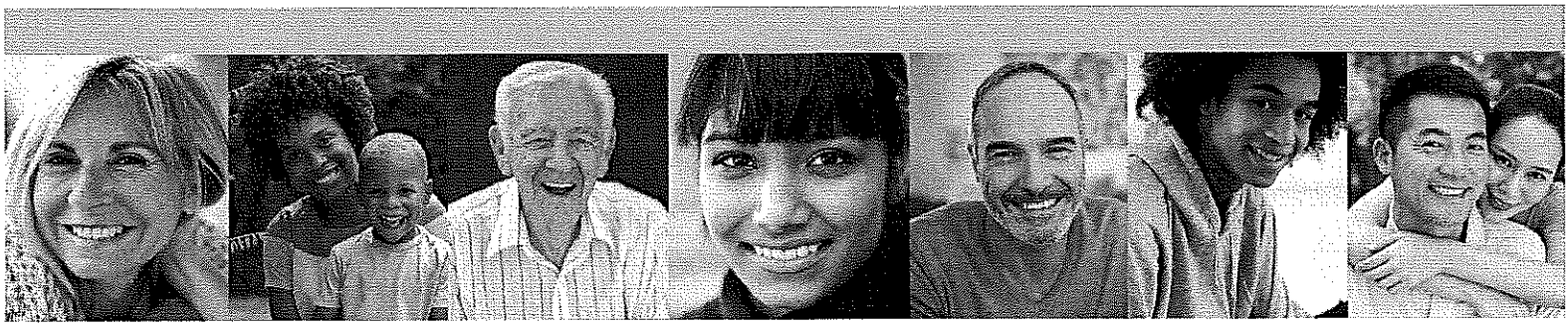
Paul Golino
Senior Vice President/Chief Financial Officer

Attachments:

Exhibit A-Notice placed regarding notification of community forum
Exhibit B-Community Forum sign-in sheet
Exhibit C-Agenda for Community Forum held May 11, 2017
Exhibit D-Article in Republican American newspaper regarding the upcoming community forum

cc: Kimberly R. Martone, Director of Operations, Office of Health Care Access,
CT Department of Health
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc

Exhibit A.



A conversation about healthcare

Community Forum

Thursday, May 11, 2017 • 6:30 p.m. – 7:45 p.m.

Waterbury Hospital, Bizzozero Conference Room (4th floor), 64 Robbins Street, Waterbury

Waterbury Hospital/Greater Waterbury Health Network invite you to attend an upcoming community forum. During this event, you will learn how exciting new developments at our organization are strengthening the care you receive.

Leaders from the Waterbury Hospital/Greater Waterbury Health Network will share the new initiatives taking place and will answer your questions.

Please join us for this forum and find out more about how we are working to shape the future of healthcare in our community.

WATERBURY HOSPITAL

Greater Waterbury Health Network

Exhibit B

Community Forum: Waterbury Hospital/Greater Waterbury Health Network
May 11, 2017
6:30 p.m.

NAME	Contact Information
Rev. Ray Odierne	rayodierne@sbcglobal.net
Jacqueline Jackson	jacquerie11@gmail.com
Bishop Fiorel French	RevLgFrench1@Aol.com
Susan Coderau	
Jory Cosgriff	
Colleen Smith	Independent Monitor NCP
William Pizzo	William.Pizzo@uconn.edu
DJ Belche	
Paul Golino	
Kevin Lucier	Harold Leever Cancer Ctr
Lorraine Shogl	Easterseals
Brian Emerick	bemerick@accessrehabcenters.com
Annie Bokuch	
Rev Dastol Rodney WADE	rdwade2002@Longhillbc.org
Becky Rutrough	BeckyRu@outlook.com

Exh. 67 B

Community Forum: Waterbury Hospital/Greater Waterbury Health Network
May 11, 2017
6:30 p.m.

NAME	Contact Information
Sue Castelli	GWHC x7103
CARL CONTADINI	
Robert A. Matusz, DPM	RPM.DPM@AOL.Com
Jeff Fonseca	JFonseca@valleyhospice.org
(Richard + Sandra Natale Naugatuck Valley Project)	rnatale0@snet.net
Ross Uffer	DRA 6279
Patty Chase	
Janine Sullivan-Wiley	(203) 757-9603 JSW@nwrmhb-ct.org
Allen Johnson	203-574-3636
Charles Organek	203-574-3611
SCOTT BOWMAN	203-720-0378
Susan Beatty	203-755-5777

Exhibit B

Community Forum: Waterbury Hospital/Greater Waterbury Health Network
May 11, 2017
6:30 p.m.

NAME	Contact Information
Jan L. Yolanda	
Kimberly A. Kuwia	(203) 573-7129 KKuwia@wtbyhosp.org
Mark Hag	203 573-7562

Exhibit C.

Agenda
Community Forum
Waterbury Hospital/Greater Waterbury Health Network
May 11, 2017
6:30 p.m.

I. Welcome & Introductions (Lester Schindel, CEO)

II. Our Focus on Quality and Patient Safety (Dr. Joey Cosgriff, Medical Director, Performance Improvement)

III. Investment in our hospital and our community (Lester Schindel, CEO)

IV. Meeting Community Health Needs (Patty Charvat, Public Affairs Director)

V. Questions & Comments

Exhibit D.

Hospital has community forum

Update will be offered

BY ALEC JOHNSON
REPUBLICAN-AMERICAN

REPUBLICAN AMERICAN ARCHIVES

Waterbury Hospital will host a community forum on Thursday.

WATERBURY — Keeping up with a condition of its acquisition by Prospect Medical Holdings last year, Waterbury Hospital is inviting the public to a community forum Thursday.

Greater Waterbury Health Network, now part of the larger Prospect, which owns 20 hospitals in six states, plans to share what's new at the hospital, its community health initiatives and an update on quality and patient safety.

Patricia Charvat, a spokeswoman for the hospital, said Lester Schindel, the new chief executive officer, will join other hospital and Prospect officials to take questions. Prospect named Schindel as CEO in March when Darlene Stromstad, the CEO since 2011, was appointed to a new role at Prospect.

Schindel was formerly CEO of Chartercare Health Partners, Prospect's two-hospital system in Rhode Island, from 2014 to 2016. He successfully oversaw Chartercare's transition to Prospect, the company stated.

Charvat said as a part of the sale state regulators asked the hospital to host two community forums a year to give the community the opportunity to learn more about what is going on at the hospital. This will be the first such meeting.

"What we will be doing is giving an update on the status of the hospital since the sale, investments that have been made and any changes that have been made," she said. "Any community member is invited to come and hear what is going on and ask any questions they may have."

The meeting will be from 6:30 p.m. to 7:45 p.m. Thursday in the Bizzozero Conference Room on the hospital's fourth floor.

Contact Alec Johnson at ajohnson@rep-am.com.

User, OHCA

From: Charvat, Patricia <pcharvat@wtbyhosp.org>
Sent: Monday, October 30, 2017 4:31 PM
To: User, OHCA
Subject: Waterbury/Greater Waterbury Health Network: Docket Number: 15-32017-486
Attachments: Waterbury Hospital GWHN letter to OHCA 103017.pdf

Good afternoon!

Attached is the required filing from Waterbury Hospital/Greater Waterbury Health Network (Docket Number: 15-32017-486). This document provides information on the Order's Condition Number 13 and Condition Number 15 regarding the transfer of assets of the Greater Waterbury Health Network/Waterbury Hospital to Prospect Medical Holdings.

Best,
Patty

Patricia Charvat
Interim Director, Communications/Public Affairs
Waterbury Hospital
203.573.6718 (office)
978.273.7764 (mobile)

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Greater Waterbury Health Network

WATERBURY HOSPITAL

October 30, 2017

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32017-486**

Project Title: **Transfer of assets of Greater Waterbury Health Network to Prospect Medical Holdings, Inc.**

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Thirteen (13) and Condition Number 15 (15) regarding the transfer of assets of Greater Waterbury Health Network (GWHN)/Waterbury Hospital to Prospect Medical Holdings, Inc. (PMH).

Condition Thirteen

Condition Number Thirteen (13) requires that "PMH shall maintain community benefit programs and community building activities for New Waterbury Hospital for three (3) years after the Closing Date consistent with Waterbury Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as the Hospital's current programs, and PMH shall apply a 1% increase per year for the next three (3) years toward community building activities in terms of dollars spent."

For fiscal year 2017, Prospect Waterbury Hospital/GWHN increased community benefits activities and community building activities that Legacy Waterbury Hospital had offered the community prior to the acquisition by PMH. Overall, PMH invested $21,433,156 in community benefits programs and community building activities in fiscal year 2017. This was $1 million more than the investments made by Legacy Waterbury Hospital/GWHN in fiscal year 2016 representing a 5% increase.

The dollar amounts of community benefits programs and community building activities for Legacy Waterbury Hospital for fiscal year 2016 that were filed with the IRS on Schedule H in August 2017 and the amounts for Prospect Waterbury Hospital/GWHN for fiscal year 2017 are included in the following table.

Total Community Benefit – Waterbury Hospital	**Legacy WH/GWHN FY 2016**	**Prospect WH/GWHN FY 2017**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	$950,442	$1,159,227
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	$9,514,951	$8,910,153
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	$9,876,970	$11, 184,873
Community Building Activities *IRS 990 Schedule H Part II, 10*	$142,530	$178,903
Total	**$20,484,893**	**$21,433,156**

Financial Assistance

Prospect GWHN/Waterbury Hospital continues to treat patients regardless of their ability to pay for services and hospital policies regarding charity care have not changed since the transaction closed. The hospital continues to provide the same level of financial assistance to patients that qualify based on need.

Community Health Improvement and Health Needs Addressed

Waterbury Hospital/GWHN is an active participation in the Greater Waterbury Health Improvement Partnership (GWHIP), the coalition that works together to identify the community's needs through a Community Health Needs Assessment (CHNA). Based on the CHNA, the group then develops strategies and action plans to address these needs through – action plans are developed both for the group as well as a plan for each organization. Within the last year, the group conducted another CHNA and Waterbury Hospital/GWHN contributed $40,600 toward this assessment initiative.

This year, the Greater Waterbury Health Improvement Partnership reviewed the findings and discussed cross-cutting approaches to further address the priority areas identified in the CHNA. The following four priority areas for Waterbury were adopted for the 2017-2019 implementation plan:

- Access to Care – including Mental Health/Substance Abuse,
- Healthy Lifestyle – including Obesity and Tobacco Use,
- Asthma, and
- Health Communications.

Access to Care

Representatives from Waterbury Hospital are currently chairing the GWHIP Access to Care Workgroup. The workgroup is working on developing infographics as a way to help people navigate the local health system for different areas including when to use ED vs. Urgent Care vs. Primary Care, Asthma, Mental Health, and Diabetes. The workgroup also continues to work on creating the Community Care Team, which will provide cross-organization case management between both hospital EDs and a comprehensive array of community organizations for high utilization emergency department visitors.

Waterbury Hospital employees contributed to the Access to Care Workgroup development of infographics for the Waterbury community and lead two sub-workgroups that worked on developing infographics for Asthma & Diabetes. We are also collaborating with the Waterbury Health Department on their Opioid grant to provide Narcan to the community.

Other Waterbury Hospital/GWHN initiatives related to Access to Care include the following.

The Waterbury Health Access Program (WHAP) improves access to high-quality medical care by providing comprehensive case management, pharmacy assistance, and access to primary and sub-specialty medical care for the uninsured and underinsured residents of the Greater Waterbury region. With the institution of the ACA, WHAP workers have become Access Health CT Assisters, have increased their navigation services to include the Medicaid population, and continue to add to its repertoire addressing the social determinants of health for those who are identified as high utilizers with chronic health conditions. During FY 2017, WHAP had over 5,726 active clients. Given the challenges of the State Budget, funding for WHAP was stalled, thus, Waterbury Hospital/GWHN covered nearly $50,000 in costs for this program.

In order to ensure that patients have access to medical appointments, at the hospital and at local physicians' offices, **Waterbury Hospital's Be Well Bus** provides transportation services to patients from Waterbury and eleven of its surrounding towns. Waterbury Hospital/GWHN covers the full cost of this service, which is $95,000.

Waterbury Hospital's Center for Behavioral Health is one of the region's largest service providers offering a full continuum of care for children, adolescents and adults. Our services include psychiatric evaluations, OT/AT evaluations, family and group therapy, didactic educational groups, individual counseling, recreational services, and mental health services. This year, the Center began an open access program in which appointments are not necessary on Monday – Wednesday each with, with the goal of expanding this to all week in the future. We also do outreach to the community through regular participation in health fairs, elected membership in the Northwest Regional Mental Health Board, as a host site to numerous twelve-step meetings, and the provision of case management as well as acute services to the homeless within the City of Waterbury. During FY 2017, the Center for Behavioral Health cared for 8,707 persons.

The Yale-Waterbury Hospital Internal Medicine Residency Program, initiated three years ago, is sponsored by Yale-New Haven Hospital and affiliated with Yale University. Activities include participation in research days at Yale and Waterbury Hospital/Saint Mary's Hospital, home and office visits for clinic patients and education seminars held at Waterbury Hospital and Yale University. In FY 2017, we had 38 residents in our program.

In addition, Waterbury Hospital/GWHN supports the education of healthcare professionals in all fields. In 2017, the hospital offered clinical training opportunities for students of college and university programs. Exhibit A lists the educational institutions that the hospital has agreements with to provide clinical experiences to students. The amount of community benefit provided by the hospital for health professionals education in 2017 was $7,380,592.

This year, Waterbury Hospital offered its Evergreen 50 wellness programs to the entire community through **two new series of educational programs**, Spring Into Wellness and Fall Into Wellness. These presentations were on a variety of health topics including heart health, depression, muscles and joint pain, osteoporosis, healthy eating, asthma, bone health, and a range or other medical topics. **The Community Educator** employed by Waterbury Hospital and Saint Mary's Hospital conducts a series of health fairs and various health and wellness education sessions, including "Health Screenings," which provides patients with complimentary blood pressure screenings and health awareness education. In addition, Waterbury Hospital/GWHN representatives participated in a number of community programs to provide health and wellness information to our communities. (See Exhibit B for a full listing of programs and participation.)

Healthy Lifestyles

GWHIP's Healthy Lifestyle workgroup is working on mapping existing community resources in order to have a database on what exists and to identify the activities and initiatives of organizations within the community. The workgroup is also working on establishing the State of CT Livewell Diabetes Self-Management Program in Waterbury or having some type of diabetes education available to the community.

To address the community's health needs related to obesity and diabetes management, Waterbury Hospital, in conjunction with local churches, launched the **Reinventing Banana Pudding** program. Through this program Waterbury Hospital hosts a cooking demonstration/nutrition (diabetes) presentation in the community. Also, Waterbury Hospital in partnership with the Western CT Area on Aging is facilitating the Livewell Diabetes Self-Management Program. In June 2017, Waterbury Hospital had three employees trained as Livewell Diabetes Facilitators. The program started on October 2, 2017 at the Saint Francis Xavier Church in Waterbury and the classes are in Spanish.

The Comprehensive Weight Management Program offers medical and surgical weight loss options for patients. Services include medical nutrition therapy, medical weight loss, and surgical weight loss. Medical Nutrition Therapy with a registered dietitian is available to patients with a variety of medical conditions such as diabetes, chronic kidney disease, hypertension, high cholesterol, as well as for those who are looking to lose weight.

The Evergreen 50 Club has 9,200 members over the age of 50. The Club offers fitness classes including weight training and Pilates, wellness classes, and health education presentations on a variety of topics are presented by healthcare professionals. This year, many of these programs were offered to the entire community.

The Food for Life Program is an innovative program that provides access to fresh fruits and vegetables and enrollment in exercise programs to qualified HIV patients at no cost. The program offers a fitness and yoga class monthly and Nutrition, Health, and Wellness Support Group biweekly to engage patients in positive activities.

The Live Well with Diabetes Workshop is a partnership with Waterbury Community Organizations to offer a six-week program open to the public that will help people learn about what to eat, foot care, blood sugar, sick day guidelines, tips for dealing with stress, how to set small and achievable goals.

Through GWHIP, we are partnering with the Waterbury Health Department for **the Putting on AIRS Program**. The ED is referring qualified patients to the Waterbury Health Department with an asthma action plan. The program is an evidenced based free home visitation program focusing on indoor asthma triggers and education about asthma as a chronic illness. Posters for the Putting on AIRS Program have been displayed in our ED in both English and Spanish.

Waterbury Hospital is participating in the CT Hospital Association Asthma Initiative which is working towards having an asthma action plan given to every patient who comes into the Emergency Department (ED) with an asthma diagnosis and providing education on proper use of inhaler. The Asthma Action Plan was updated to match the CT Department of Public Health and was put into the Cerner System by our IS Department in March 2017.

Health Communications

The Health Communications Workgroup was a new work group that was added after the 2016 CHNA process. The workgroup's goal is to increase messaging and communications to the partners, community organizations, and the Greater Waterbury community. They have identified a vendor that will be in charge of the web design, social media, logo, and color scheme and the work should be completed by Fall 2017.

Waterbury Hospital's PR Department is currently including information on community events and programs on the Waterbury Hospital's website – community calendar, Facebook page, and Evergreen newsletter.

Our Community Health Needs Assessment and Implementation Plan can be found on our website: http://www.waterburyhospital.org/community/chna/2016-chna-final-report/ http://www.waterburyhospital.org/community/chna/2016-chna-implementation-plan/

Community Building Activities

The WH Youth Pipeline Initiatives were established in 2001 as a partnership between Waterbury Hospital and Waterbury Public Schools. The mission of the program is: "to close the achievement gap for minority and economically disadvantaged students in Waterbury so they can matriculate and compete nationally for placement in post-secondary education programs in preparation for health careers." WH has remained committed to enhancing and enriching the academic opportunities and personal journeys of our youth, who are the emerging workforce of tomorrow. During 2017, WH provided 78 students and parents in Greater Waterbury with unique educational programs that will enhance the overall welfare of our community. Previously funded by grants, Waterbury Hospital/GWHN now covers $104,573 in costs for these essential community programs.

The WH Youth Pipeline Initiatives had five focus areas during FY 2017, including:

1. **Parent Leadership Training Institute (PLTI)** – In 2017, nine individuals from Greater Waterbury successfully completed Waterbury's PLTI, a 20-week curriculum teaching leadership and advocacy skills, as well as individual community project planning. PLTI's core mission is to impart leadership and advocacy skills to parents while simultaneously educating them about volunteerism, civic life, and the process by which state and local governments enact and change laws. Each participant completes and implements a community project.
2. **Children Leadership Training Institute (CLTI)** – CLTI is run in connection with the PLTI program. 10 children participated in the program in 2017.
3. **UConn People Empowering People (PEP)** –The program included a 10-week parent leadership and advocacy regimen through which eight participants successfully completed the PEP course. UConn PEP is a personal, family, and leadership development program with a strong community focus. PEP is designed to build on the unique strengths and life experiences of participants and emphasizes the connection between an individual and community action. Participants work individually or collaboratively to create a community project which is completed as portion of the program. Waterbury Hospital/GWHN conducts three PEP programs, one in English, one in Spanish and one in Albanian.
4. **WH PEACH Spring Break Program** – The PEACH Spring Break Program is a three-day program for middle school students. During their time at the hospital, 27 students complete hands-on learning activities including: CPR or First Aid Certification, nutrition class, job shadowing, and a fieldtrip.

5. **WH Summer Bridge Program** – During the summer of 2017, 24 students from Waterbury, grades 6-11, participated in the WH Summer Bridge Program. The students participated in academic classes, the Poetry Slam, attended a medical module at Stone Academy, science module at Naugatuck Valley Community College – Starbase, and worked with the Waterbury Health Department Assistant Director to include pictures, recipes, and tips on website.

Waterbury Hospital/GWHN community building activities go beyond these programs. Staff from both the hospital and GWHN volunteer to serve on boards and committees of local charitable organizations and Chambers of Commerce. In addition, Waterbury Hospital and GWHN sponsored local charitable organizations' fundraising events. The organizations which Waterbury Hospital/GWHN has provided support for are listed in Exhibit C; support is defined as both financial support and employee participation.

Throughout Fiscal Year 2017, the community benefit initiatives of Waterbury Hospital/GWHN engaged nearly 35,000 people.

Condition Fifteen

A Condition Number Fifteen (15) states that New Waterbury Hospital shall work toward making culturally and linguistically appropriate services available and integrated throughout the hospital operations guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. In addition, the New Waterbury Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served in accordance with the regulations of Section1557 of the Patient Protection and Affordable Care Act. Finally, New Waterbury Hospital shall provide insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees.

Prospect Waterbury Hospital/GWHN is committed to making culturally and linguistically appropriate services available and integrated throughout the organization, providing meaningful access to individuals with limited English proficiency, providing insurance navigator services and providing cultural competency training for all employees.

Waterbury Hospital has Corporate Administrative Policies in place to ensure persons with limited English proficiency and persons requiring auxiliary aids and services have access to the healthcare services available at the hospitals and throughout the organization. They include:

Policy: Assessment of Patients – Deaf and Hard of Hearing People (Exhibit D)
Policy: Patients Rights/Organization Ethics – Foreign Language Interpreter Service (Exhibit E)

These policies are available on-line for all employees. Waterbury Hospital offers access to auxiliary communication aids and services, including alternative formats and sign language interpreters, for individuals with disabilities. Information about these services are posted throughout the hospitals.

Also posted throughout the hospitals is a notice of consumer rights, providing information about communication assistance, with tag lines posted in the top 15 languages spoken by individuals with limited English proficiency, indicating the availability of such assistance.

Waterbury Hospital/GWHN partners with Cyracom to provide interpretation services for patients. All of these services are provided at no cost to our patients. All staff is educated annually on these policies and procedures and the services are used without hesitation to serve the needs of our patients. Video Remote Interpreting (VRI) equipment is available for use throughout the organization.

Additionally, New Waterbury Hospital provides insurance navigation services for uninsured patients who are identified as eligible for Medicaid or have the financial ability to purchase health insurance. The Charity Care and Financial Assistance Policy and Procedure describes the services provided (Exhibit F). The policy is available on the GWHN website. Waterbury Hospital contracts with MedData to make a Medicaid Eligibility counselor available Monday through Friday during normal business hours to assist patients with determining eligibility and the application process. Waterbury Health Access Program representatives are available Monday through Friday to assist the outpatient population with determining eligibility and the application process.

Two full-time Financial Counselors are employed by the hospital to assist eligible patients in obtaining health insurance.

New Waterbury Hospital's commitment to enhancing cultural awareness and embracing diversity is evident through numerous employee education initiatives including:

- New Employee Orientation: Diversity training is provided to all new staff members of the Waterbury Hospital as part of orientation. An online course entitled, "Diversity in the Workplace," developed by Health Care Compliance Strategies, a HealthStream Company, is included with general information about culture, belief systems and cultural responsiveness
- Annual Mandatory Education: This requirement of all employees includes a review of the patient experience, the organization's mission and core values, and a review of services and equipment available for patients and families who are visually impaired, deaf or hearing impaired, speech impaired or with limited English proficiency. All staff members complete an online course entitled "Rapid Regulatory Compliance," developed by Health Care Compliance Strategies, a HealthStream Company, which is included with general information about nondiscrimination.

- Additional Education: New Waterbury Hospital/GWHN employees use the HealthStream Online Learning Center for staff to complete various online education modules throughout the year.

Waterbury Hospital/GWHN are committed to improving the health and quality of life of our community and are very proud of the many initiatives conducted by the employees and medical staff members of GWHN. We look forward to continuing our work for and with the community.

If you have any questions or need anything further, please feel free to contact me at (203) 573-7101.

Very truly yours,

Peter Adamo

Enclosures

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consultant Partners, LLC
Von Crockett, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Exhibits

Exhibit A – Waterbury Hospital Affiliations with Educational Institutions

Exhibit B – Community Outreach Programs & Engagement

Exhibit C – Community Organizations Supported by Waterbury Hospital

Exhibit D – Policy: Assessment of Patients – Deaf and Hard of Hearing People

Exhibit E – Policy: Patients' Rights/Organization Ethics – Foreign Language Interpreter Service

Exhibit F – Charity Care & Financial Assistance Policy

Exhibit A – Waterbury Hospital Affiliations with Educational Institutions

Bridgeport Hospital School of Nursing
Capital Community College Paramedics
Central Connecticut State University
Frank H. Netter MD School of Medicine at Quinnipiac University
Gateway Community College (4 different health professional programs)
Goodwin College
Hoffman Heart and Vascular Institute of CT Vascular Tech
Kinds College Physician Assistant Program
MCPHS University
National Medical Education and Training Center, Inc.
Naugatuck Valley Community College (School of Nursing)
NorthWestern Connecticut Community College School of Nursing
Nova Southeastern University Biomedical Informactics Program
Post University
Quinnipiac University (3 medical professional programs)
Sacred Heart University
South Connecticut State University School of Nursing
Springfield College Physician Assistant Program
St. George's University Sub-Interns
Stone Academy
Tufts University Physician Assistant Program
UConn Pharmacy
UConn School of Nursing
University of Bridgeport Medical Laboratory Services
University of Bridgeport (PA programs)
University of Connecticut School of Medicine
University of St. Joseph School of Nursing
University of St. Joseph Dietetics Program
Western CT State University School of Nursing
Wilby High School
Yale School of Medicine
Yale School of Nursing

Exhibit B – Community Outreach Programs & Engagement (FY17)

Fall into Wellness/Spring into Wellness Talk Series

- Nutrition tips at any age, Kendall Dyer, Registered Dietician, Waterbury Hospital/Alliance Medical Group
- Mind, Body and Soul Wellness, D. Kothari, Geriatrician, Waterbury Hospital (2 hours, MD)
- Managing Depression in the elderly. Dr. Leonard Stern, Waterbury Hospital Geriopsychiatry.
- Are you at risk for osteoporosis? Joan Doback, PA, Waterbury Hospital Bone Health Center
- Managing Muscle and Joint Pain with Dr. Tejas Sheth, rheumatologist with Alliance Medical Group/Waterbury Hospital

Special Screenings for the Community

November 7 – Alpha 1 Lung Screening. Screenings include genetic screening for the Alpha 1 protein deficiency and screening for COPD. Event co-sponsored with Alpha 1 Foundation and Waterbury Pulmonary Associates.

Sept. 22 Fall Prevention Day Greater Waterbury Health Network at Waterbury Hospital

Outreach in the Community:

Oxford Senior Center, Mind, Body and Soul Wellness, Dr. Kothari

Middlebury Senior Center, Mind, Body and Soul Wellness, Dr. Kothari

Woodbury Senior Center, The Importance of Sleep, Saloua Mabkhouti, APRN

Naugatuck Senior Center Health Fair, Dr. Silva

Reinventing Banana Pudding Food Demonstration and Diabetes Education Series, Community Tabernacle and Waterbury Health Fair

Village at East Farms, Talks on Poli-pharmacy, Waterbur Hospital Pharmacist
Falls Avenue Senior Center (Watertown), Dr. Kothari presentation

Jewish Federation Wellness Event, Southbury, Waterbury Hospital RN

Village at East Farms, Waterbury, Fall Prevention Lecture

Exhibit B – Community Outreach Programs & Engagement (FY17) – continued

Greater Waterbury Spirit of Unity Festival Health Fair, health screenings by RN

Walk from Obesity – Hubbard Park, Bristol

Naugatuck Senior Day, PT and RN screening

Just For the Health of It, Oxford Senior Center Fair, PT and RN Screening

Harold Leever Regional Cancer Center, Colorectal Awareness Presentations by Dr. Zhang

Classes and support groups include:

Bereavement Group "Journey Through Grief"
8-week sessions with Pastoral Care and Case Management

Diabetes Management
Manejo Personal de la Diabetes – (Live Well with Diabetes) 9 a.m. to 12 p.m., St. Xavier Church, 625 Baldwin Street (Waterbury Hospital Sponsored)
Manejo Personal de la Diabetes Rivera Baldwin Center, 135 East Liberty Street (Hispanic Coalition sponsored).

Weight Loss Surgery Support Group
Mind Full Eating is Not Mindful Eating

Intermediate Pilates
8 Week sessions, four times a year

Weight Training
12-week sessions, 3 times this year

Movie Series for Evergreen 50 Club Members (once a month)

Exhibit C – Community Organizations Supported by Waterbury Hospital

Acts 4 Ministry
Albanian/American Muslim Community
American Cancer Society
American Legion
Boy Scouts
EasterSeals
Girls, Inc.
Greater Waterbury Health Improvement Partnership
Greater Waterbury Interfaith Ministries
Litchfield County Fire Chiefs Board of Directors
March of Dimes
Mattatuck Museum
Mayor's Drug Task Force
Neighborhood Housing Services of Waterbury
Naugatuck Senior Center
Northfield Fire Company
North and South Foundation
Pomperaug Health District
Pomperaug River Watershed Coalition
Rotary and Rotary International
Safe Haven of Greater Waterbury
Silas Bronson Library
Stone Academy Academic Advisor
St. Vincent DePaul Shelter
United Way of Greater Waterbury
VFW
Waterbury Development Corporation
Waterbury Hospital Auxiliary Inc.
Wolcott Board of Education
Waterbury Ole Skool
Waterbury Neighborhood Council
Waterbury Police Explorers
Waterbury Public Schools
Waterbury Regional Chamber
Wolcott High School Robotic Team

Exhibit D – Policy: Assessment of Patients – Deaf and Hard of Hearing People

POLICY: DEAF AND HARD OF HEARING PEOPLE		
CATEGORY: ASSESSMENT OF PATIENTS		PAGE (s): 7
OWNER: TELECOMMUNICATIONS COORDINATOR		ORIGINATED: 4/15/95
LAST REVIEWED: 07/16	LAST REVISED: 10/17	RETIRED:

SCOPE: All Healthcare providers

PURPOSE: To provide staff with information that will enable them to provide effective communication with deaf or hard of hearing patients, family members or companions during their Waterbury Hospital experience. In accordance with state and federal laws as well as regulatory guidelines, responsible heath care providers will ensure that auxiliary aids and sign language services are provided when appropriate or upon request.

POLICY:

Interpreter Services will be provided for all patients and/or their families/companions as requested or required. Video remote interpreters are available 24/7. In-person interpretation needs to be scheduled in advance for non-emergency situations when video remote interpreting is not appropriate.

1. Arrange for **video interpreting** by notifying your supervisor or the administrative nursing supervisor on the off shift or weekends to retrieve the video remote equipment cart. Video interpreting services are provided by CyraCom and are available 24/7. Instructions for use are attached.

2 If video remote interpreting is not appropriate then follow the instructions below to obtain an in-person interpreter:

- Contact Life Bridge (formerly FSW Inc). at 1-888-676-8554. During evenings, nights, and weekends, this number rolls over to 2-1-1. Let it ring through (it could be up to 10 rings).
- In the event that LifeBridge is not available to provide services, call 9+211. 2-1-1 is a statewide resource to find sign language interpreting service providers.
- If an interpreter is not available through either LifeBridge or 2-1-1, please contact your supervisor or the administrative nursing supervisor during off shift or weekends.

  Inform the patient, family member or companion of the efforts you have taken to obtain an interpreter, and that those efforts have been unsuccessful. Any reasonable suggestions for locating an interpreter by the patient or family member should be followed, such as contacting an interpreter known to that person. This is an interim step. Attempts to locate a certified interpreter must continue. This shall be documented in the record.

  When an interpreter is obtained, inform the patient, family member, or companion that arrangements have been made for an interpreter and the anticipated time of arrival. Document all steps you have taken to obtain an interpreter in the patient record.

TTY Relay Services

If you need to contact a deaf patient over the telephone, you will use the Connecticut Relay Service.
A free public service for communication between standard (voice) users and persons who are deaf, hard-of-hearing, deaf-blind, and speech-disabled using text telephones (TTYs) or PCs via the Internet. To reach the relay, service dial 9+1+711.

Other Communication Services

Family members, except with full permission of the individual, should not be utilized solely as interpreters, as they may not be able to fully translate complex medical information, and patient confidentiality could be jeopardized.

If a patient or family member insists, an interpreter may be released only after the initial contact is made. Documentation must be concise and must validate that the patient or family member is requesting termination of interpretive services. This needs to be documented in the patient record.

All available resources will be used until a sign language interpreter arrives including staff that knows American Sign Language, written communication (clipboard, paper, pen), and auxiliary aids such as TTY.

Auxiliary aids available for Deaf and Hard of Hearing persons

- TTY (print)
- Visual alarms
- Amplified telephones
- Flashing light signals for telephones
- Assisted listening devices
- Closed-captioned TV's
- Waiting rooms equipped with a "courtesy" telephone can also be utilized for TTY's. To utilize these courtesy phones, access the TTY assigned to the department or call the operator.

Auxiliary aids have been assigned to patient care areas (contact your Department Manager for location of equipment) or they can be obtained through Security (dial 0) or the Program Administrator at ext. 7201.

Program Administrator

If you have general questions on the deaf and hard of hearing and available services, please contact your supervisor or the administrative nursing supervisor during off shift or weekends.

CYRACOM

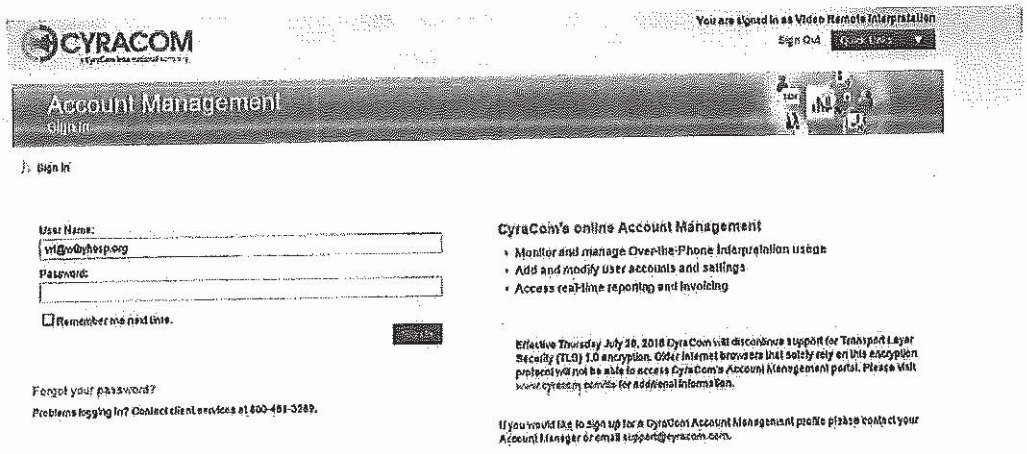
VRI User Quick Start Guide

A quick reference guide on how to access Cyracom's Video Remote Interpretation service

Waterbury Hospital

1. Power Up Dell Laptop
2. Turn power on Speaker/Microphone (on top of monitor)
3. Sign into Account Management Portal:

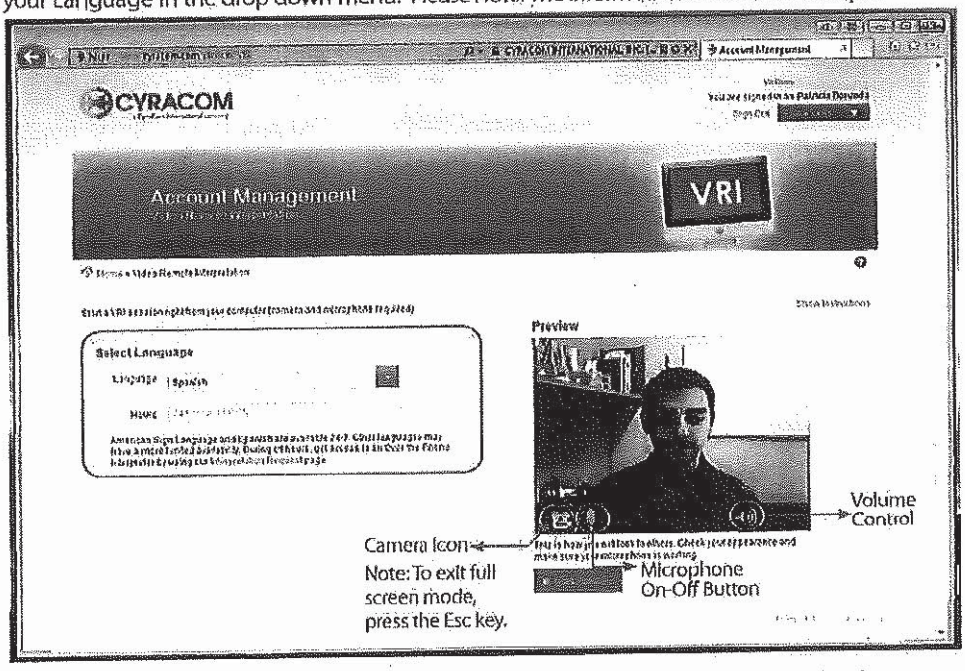
User Name: vri@wtbyhosp.org
Password: wtbyhosp1



CYRACOM

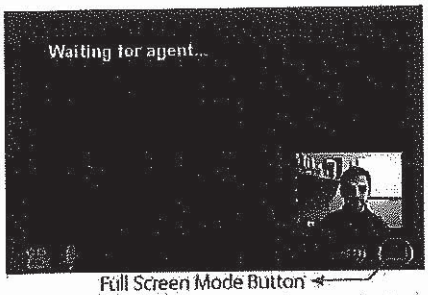
Step 4: Setup VRI Session

Select your Language in the drop down menu. *Please Note: The information below is an example.*



Step 5: Begin VRI Call

Click the Start Session button to begin.



Step 6: End VRI Call

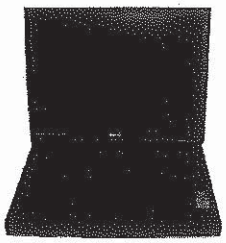
Click the Stop Session button to end the VRI call.

If you have any questions, contact your Account Manager, call our Client Services at 1-800-481-3289, or email us at support@cyracom.com.

Your Account No.: 501019763

Your PIN No.: 7809

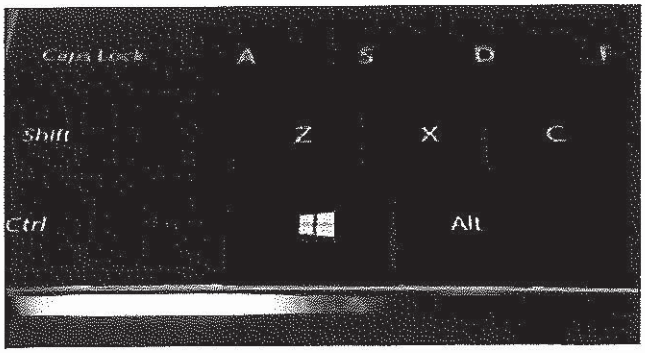
SPECIAL NOTES FOR DELL INSPIRION 17, 5000 SERIES



POWER BUTTON: Round button located above the keyboard.

TO SHUTDOWN:

Press Windows key on the keyboard.

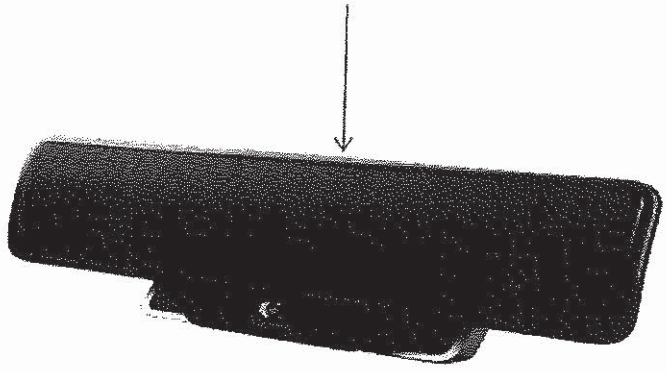


Click on Shutdown.

LOGITECH LAPTOP SPEAKER Z305

Power Button

(blue light comes on when power is on)



DEAF AND HARD OF HEARING PEOPLE

Approved: _____ 10-30-17
Pat Robinson
Telecommunications Coordinator
Date

Approved: _____ 10-30-17
Chief Information Officer
Date

Approved: _____ 10-30-17
Renee Mauriello, RN, NEA-BC
CNO/VP Patient Care Services
Date

Exhibit E – Policy: Patients' Rights/Organization Ethics – Foreign Language Interpreter Service

POLICY: FOREIGN LANGUAGE INTERPRETER SERVICE		
CATEGORY: PATIENT RIGHTS/ORGANIZATION ETHICS		PAGE (s): 6
OWNER: CHIEF INFORMATION OFFICER		ORIGINATED: 10/1/00
LAST REVIEWED: 7/16	LAST REVISED: 10/17	RETIRED:

SCOPE: Applies to all employees.

PURPOSE: To identify an appropriate resource for interpreter services by qualified individuals to patients whose primary language is other than English in an effort to ensure effective communication. Effective communication is the basis of the trusting relationship between patients and healthcare providers and can improve patient safety. Waterbury Hospital will provide patients of Limited English Proficiency (LEP) and their companions who are designated to communicate with medical personnel, interpretative services as necessary for effective communication in the delivery of quality medical care.

POLICY:

1. Ensure that vital medical information is interpreted by certified, professional interpreter by using CyraCom Telephonic Interpreter services for:
   - health assessment, detailed present/past health history
   - explanation of diagnosis or diagnostic test results
   - treatment options
   - consent for treatment, surgery, blood or procedures
   - detailed discharge instructions, medication regime, and necessary follow-up
   - or any other vital information

2. For other interpretation needs:
   - Bilingual employees within a department who are fluent in the patient's language or a family member with the patient's permission can assist with basic patient identification, demographics, and to convey information to inform, reassure or gain cooperation of the patient with routine patient care.
   - Use of non-Waterbury Hospital personnel, friends, family, or waiting room by-standers constitutes a violation of confidentiality if used to translate any protected health information. With the patient's permission, such persons may be used to translate non-vital medical information.

3. Equipment:
   - Each WHHC inpatient unit and outpatient department will be assigned a dual handset telephone that may be used for over the telephone interpretation.
   - Speaker phones may also be used as long as patient privacy/confidentiality is maintained.
   - Department managers are responsible for establishing a safe place to store the interpreting phones and for informing staff about the location, setup and storage of the same.
   - The inpatient unit and other departments will be responsible for returning defective/damaged equipment to the Telecommunication Coordinator in the IS Dept.
   - The Telecommunication Coordinator will arrange for repair or replacement of the telephone and will maintain an adequate number of spare telephones.

4. Documentation:
   - The use of interpretive services must be documented in a clinical document.
   - If a patient refuses the interpreter services or services are unable to be used due to patient condition, this must be documented in a clinical document.

CYRACOM
Transparent Language Services

Accessing a Medical Interpreter

Using Any Phone

Dial **1-800-481-3293** to access the interpretation services.

When prompted, enter your 9-digit account number: 501019763

At the second prompt, enter your 4-digit PIN number: 1000

Say the language you need.

Select if you would like to add an additional person to the call.

When the interpreter comes on the line, give the interpreter a brief explanation of the call.

Additional Person Anytime Option

With this option, in addition to having the interpreter and the patient on the call, you can conference in another person. You can also use this option to make outbound calls to a patient with the interpreter on the line with you.

To add the additional person at the start of your interpretation session:

Press "1" when prompted if you would like to add an additional person to the call. Follow the prompts to enter the person's phone number.

When the interpreter greets you, say you are adding an additional person. Give the interpreter the name of the person you are calling and the purpose of the call.

Press "1" when you are ready to connect the additional person to the call.

To add an additional person when the interpretation session is already in progress:

Press *8 to be prompted to enter the additional person's phone number, or ask the interpreter to add the additional person for you.

Working Effectively with a Medical Interpreter

Allow the interpreter to greet you and to provide an interpreter ID number.

Write the interpreter ID number in the patient's file or progress notes for documentation.

Provide the interpreter with a brief explanation of the call.

Allow the interpreter to introduce him/herself to the patient.

Speak directly to your patient and make eye contact.

Speak in the first person.

Use short but complete phrases.

Avoid slang, jargon or metaphors.

Allow the interpreter to clarify linguistic and cultural issues.

Remember that everything is repeated and kept confidential.

Identifying Your Patient's Language

This chart reads, "Do you speak [language]"? Show this chart to your patients and have them point to their language.

Arabic	هل تتكلم اللغة العربية ؟
Bengali	আপনি কি বাংলা বলতে পারেন?
Bosnian	Govorite li Bosanski?
Cambodian	តើអ្នកនិយាយភាសាខ្មែរ ឬទេ?
Cantonese	您講廣東話嗎？
Chinese	您讲中文吗？
Farsi	آیا شما فارسی صحبت میکنید؟
French	Parlez-vous français?
Haitian Creole	Èske ou pale Kreyòl?
Hmong	Koj puas hais lus Hmoob?
Italian	Parlate italiano?
Japanese	日本語を話しますか。
Korean	한국어 통역이 필요하십니까?
Mandarin	您讲普通话吗？
Polish	Czy mówi Pan/Pani po polsku?
Portuguese	Você fala português?
Russian	Вы говорите по-русски?
Somali	Af Soomaaliga ma ku hadashaa?
Spanish	¿Habla español?
Vietnamese	Ông/bà nói tiếng Việt phải không?

For 24-hour assistance call Client Services at 800-481-3289.

Learn more at **www.cyracom.com**

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Contains Proprietary Information and is for the use of Waterbury Hospital only.
FOREIGN LANGUAGE INTERPRETER SERVICE

CYRACOM.
How Interpretation Should Be

Language List

Our language list contains languages coded into our calling platform. When entering the corresponding code while calling CyraCom, the call will route to the interpreter queue for that language. The availability of interpreters for some less-frequently-used languages may vary, and increased requests for languages help us gauge demand and may influence interpreter staffing changes. If an interpreter for the language you are looking for is not currently available, your call will route to Client Services for further assistance.

Afghan	265
Afrikaans	224
Akan	016
Akateko	418
Albanian	070
Amharic (Ethiopia)	027
Arabic	090
Armenian	072
Armenian (Eastern)	420
Armenian (Western)	421
Ashanti	365
Assyrian	139
Azerbaijani	109
Bambara	019
Belarusian	225
Bemba (Zambia)	324
Bengali	084
Berber	269
Bhutanese/ Dzongkha	391
Borana	382
Bosnian	263
Brazil-Portuguese	270
Bulgarian	069
Burmese	042
Cambodian	048
Cantonese	031
Cape Verdean	013
Cebuano	122
Chaldean	138
Chamorro	403
Chao Chow	038
Chin	378
Chin (Falam)	405
Chin (Hakha)	406
Chin (Tedim)	408
Chin (Zophei)	407
Chinese	030
Chiu Chow	346
Chungshan	034
Chuukese	316
Crioulo	341
Croatian	067
Czech	063
Danish	055
Dari (Afghanistan)	111
Dinka (Sudan)	131
Dutch	056
Ebon	272
Edo	273
Egyptian Arabic	398
Eritrean	274
Estonian	077
Ethiopian	275
Ewe	321
Fanti	074
Farsi	107
Filipino	395
Finnish	052
Flemish	227
Foochow	276
French	058
French Cajun	277
French Canadian	383
French Creole	217
Fukienese	032
Fulani	014
Fuzhou	229
Ga	230
Garri	388
Georgian	216
German	057
Greek	071
Guamanian	125
Gujarati	083
Gulf Arabic	401
Haitian Creole	129
Hakka	039
Hamer-Bana	396
Hausa	022
Hebrew	106
Hindi	082
Hmong	046
Hokkien	286
Hunanese	147
Hungarian	065
Ibo	218
Ilocano	113
Ilonggo	121
Indonesian	050
Iraqi Arabic	399
Italian	059
Japanese	040
Jingpho	379
Jula	328
Kachchi	371
Kamba	412
Kanjobal	288
Karen	369
Karenni/Kayah	384
Kashmiri	237
Kazakh	238
Khmer	023
Kikuyu	239
Kinya/Rwanda	366
Kirundi	338
Kiswahili	424
Kizigua	425
Kongo	376
Korean	041
Krahn	320
Kunama	370
Kurdish	140
Kurdish (Badini)	414

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ISO 9001:2008, 13485:2016, 17100:2015
Quality Management System
Guidelines for Community Interpreting
Translation Services

CYRACOM.
How Interpretation Should Be

Kurdish (Kurmanji)	375
Kurdish (Sorani)	375
Kyrgyz	240
Lao	043
Levantine Arabic	402
Lingala	024
Lithuanian	075
Luo	329
Mayy Somali	315
Macedonian	068
Malay	051
Malayalam	088
Malinke	354
Mandarin	035
Mandingo	015
Mandinka	246
Marathi	205
Marshallese	291
Mien	045
Mirpuri	373
Mixteco	292
Mixteco Alto	415
Mixteco Bajo	416
Mola/Mossi	389
Moldovan	340
Mongolian	150
Montenegrin	339
Moroccan Arabic	381
Navajo	144
Neapolitan	249
Nepali	081
Nigerian English Pidgin	363
Norwegian	054
Nuer (Sudan)	294
Oromo (Ethiopia)	251
Ouatchi	386
Pashto (Afghanistan)	110
Persian	297
Pidgin English	254
Polish	062
Portuguese	061
Portuguese Creole	141
Punjabi	080
Quechua	145
Quiche	317
Romanian	066
Russian	078
Samoan	126
Saudi Arabic	400
Serbian	148
Serbo-Croatian	299
Shanghainese	037
Sichuan/ Szechuan	333
Sicilian	256
Sinhala	089
Slovak	064
Slovakian	301
Slovenian	134
Somali	142
Soninke	312
Soninke (Maraka)	413
Soninke (Sarahuleh)	337
Soninke (Sarakole)	419
Spanish	060
Sudanese Arabic	311
Swahili	026
Swahili (Kibajuni)	422
Swedish	053
Sylheti	377
Tadzhik	302
Tagalog	117
Taiwanese	033
Tamil	137
Telugu	303
Thai	047
Tibetan	105
Tigrigna (Eritrea)	028
Toisan	305
Toishanese	036
Tongan	128
Trukese/Chuukese	342
Turkish	112
Twi	095
Ukrainian	076
Urdu	079
Uzbek	336
Vietnamese	049
Visayan	214
Waray-Waray	119
Wolof	020
Wuxinese	260
Yemeni Arabic	387
Yiddish	135
Yoruba	021
Yugoslavian	262
Zambal	115

Contact CyraCom

Contact CyraCom today to discuss how we can improve your language services program.

Phone: (800) 713-4950, ext. 1 | Fax: (520) 745-9022 | info@cyracom.com | www.cyracom.com

Mailing Address: CyraCom | 5780 North Swan Road | Tucson, Arizona 85718

Learn more at www.cyracom.com
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9001:2008, 13485:2016, 17100:2015
Quality Management System
Guidelines for Community Interpreting
Translation Services

Interpreters Available

You have access to interpretation services 24/7 at no personal cost to you.
Ask your healthcare provider for help.

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Shqip (Albanian)

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.

Polski (Polish)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.

Italiano (Italian)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd gou lang ki disponib gratis pou ou.

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

(Arabic)

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

WATERBURY HOSPITAL

World Class Care. ***Right At Home.***

Greater Waterbury Health Network

FOREIGN LANGUAGE INTERPRETER SERVICE

Approved: _____ 10/30/17
Pat Robinson
Telecommunications Coordinator
Date

Approved: _____ 10/30/17
Chief Information Officer
Date

Exhibit F – Charity Care & Financial Assistance Policy

POLICY: CHARITY CARE		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 3
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 12/5/97 (From PAFS manual)
LAST REVIEWED: 8/15	LAST REVISED: 10/17	RETIRED:

SCOPE: Determination of when charity care is appropriate.
PURPOSE: To make provisions for situations in which charity care is appropriate based on aggregate balance and Encounter review.

POLICY: It is the policy of Waterbury Hospital to appropriately offer charity care in situations where the responsible party for the balance due does not have the financial resources necessary to satisfy their obligation within a reasonable period of time.

1. All patients who request consideration for charity care will be required to apply for public assistance in addition to completing a charity care application unless identified as ineligible by a qualified case worker.

2. In order to be considered for charity care, full financial disclosure is required including:
    a. All sources of income available at the time of application;
    b. Assets excluding;
        i. Primary Residence;
        ii. Vehicles required for commuting to or facilitating employment;
        iii. Retirement Accounts.

3. Responsible parties with assets of $7,500 or less ($15,000 for a couple) will receive the following discounts based on their annual household income and the published federal poverty guidelines in effect at the date of application:

Income as a % of FPL	Discount
<200%	100%
<= 225%	60%
<= 275%	40%
<= 300%	20%
<= 400%	10%

4. Charity care discounts are to be applied after the 50% uninsured discount from charges.

5. Documentation required to validate declarations made on the charity care application shall include:
    a. A credit report;
    b. Most recent 1040 tax return;
    c. Copies of all bank statements to include but not limited to:
        i. Checking accounts;
        ii. Savings accounts;
        iii. Investment accounts;
        iv. Certificates of deposit
    d. Proof of income for the immediate 12 months preceding the application date.
    e. Public assistance determination.

PROCEDURE:

1. The availability of charity care will be disclosed on all dunning notices issued prior to bad debt assignment.

2. Patients who indicate they are unable to pay for services rendered will be offered charity care;

3. Financial Counselors shall evaluate each applicant's eligibility.

4. Accounts determined to be eligible for charity care discounts shall require the following authorization based on amount to be adjusted:
   a. PAFS Manager < $5,000
   b. PAFS Director $5,000 or more
   c. Chief Financial Officer $10,000 or more

5. Patients shall be issued a determination letter within 30 days of receipt of a completed charity care application.

6. Patients who do not apply for or do not qualify for charity care will be expected to pay the balance due. For uninsured patients, this will be equivalent to 50% of charges. Insured patients will be expected to pay any deductible or co-payment due in addition to 50% of non-covered charges.

7. Patient who do not enter into a payment plan or pay satisfy the balance due will be placed with a collection agency for further collection efforts. The collection agency may report the balance due to credit reporting bureaus and/or initiate legal action to resolve the debt.

Approved: _____ 10/30/17
Director, PAFS Date

Approved: _____ 10/30/17
Paul Golino Date
CFO/VP Finance

POLICY: UNINSURED PATIENT DISCOUNT		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 4/13
LAST REVIEWED: 4/17	LAST REVISED: 10/17	RETIRED:

SCOPE: All PFS and Patient Access staff.
PURPOSE: To align balances due from uninsured patients with payments received from insurance carriers.

POLICY:

1. Uninsured patients shall be entitled to a discount of 50% of charges.
2. This discount shall be posted to the patient's account at the time a final bill is generated.
3. Any additional discounts such as prompt pay or charity care shall be calculated after the uninsured discount is applied.
4. Accounts forwarded to collections shall be placed net of the uninsured discount.

PROCEDURES:

1. Posting of the uninsured discount shall be automated through the HIS in place at the time the bill is generated.
2. In the event insurance coverage is identified after the uninsured adjustment has been posted, the adjustment shall be reversed and any applicable contractual allowance posted as per standing protocol for the specific payer.

UNINSURED PATIENT DISCOUNT

Approved: _____ 10/30/17
Director, PAFS — Date

Approved: _____ 10/30/17
Paul Golino
CFO/VP Finance — Date

User, OHCA

From: Roberts, Karen
Sent: Friday, November 17, 2017 11:01 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: Request for an extension

From: Martone, Kim
Sent: Friday, November 17, 2017 10:59 AM
To: 'Golino, Paul' <pgolino@wtbyhosp.org>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Request for an extension

Paul, that is fine. Extension is approved.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Golino, Paul [mailto:pgolino@wtbyhosp.org]
Sent: Friday, November 17, 2017 10:47 AM
To: Martone, Kim; Roberts, Karen
Cc: Golino, Paul
Subject: Request for an extension

Kim/Karen,

I'm writing to request an extension for a filing that is due November 30 for DN# 15-32017-486. Conditions 8, 9 and 10 from that decision require us to file financial information and our finance staff have asked if it is possible to move the due date to December 15. We are currently in the middle our audit.

Please let me know. Thank you.

Sincerely,

Paul

Paul Golino
CFO
Greater Waterbury Health Network
pgolino@wtbyhosp.org
Office: 203.573.7280

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User, OHCA

From: Charvat, Patricia <pcharvat@wtbyhosp.org>
Sent: Tuesday, November 28, 2017 1:36 PM
To: User, OHCA
Cc: Martone, Kim; Colleen Smith; Adamo, Peter; Lumia, Kim; von.crockett@prospectmedical.com; Ellen J. Shin (Legal Department); Frank Saidara (frank.saidara@prospectmedical.com); Garrison De Lee (Legal Department)
Subject: Waterbury Hospital/GWHN 11/16 community forum materials
Attachments: Waterbury Hospital GWHN letter to OHCA November 28 2017.pdf

Good afternoon:

Enclosed please find the announcements, agenda and presentation, and other materials related to the November 16 community forum held by Waterbury Hospital/Greater Waterbury Health Network in accordance with Condition Number 19 of the Order from the CON Final Decision for the transfer of assets of GWHN to Prospect Medical Holdings.

Please let us know if you have any questions or require additional information.

Best,
Patty

Patricia Charvat
Interim Director, Communications/Public Affairs
Waterbury Hospital
203.573.6718 (office)
978.273.7764 (mobile)

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WATERBURY HOSPITAL

Greater Waterbury Health Network

November 28, 2017

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Docket Number: 15-32017-486

Project Title: Transfer of assets of Greater Waterbury Health Network to Prospect Medical Holdings, Inc.

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Nineteen (19) regarding the transfer of assets of Waterbury Hospital/Greater Waterbury Health Network to Prospect Medical Holdings, Inc. (PMH).

Condition Number Nineteen (19) requires that PMH shall "hold a joint meeting of the Board of Directors of the New Hospital Board and the Local Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospital,' activities and afforded an opportunity to ask questions and make comments."

A Joint Meeting of the Boards of Directors for Waterbury Hospital/Greater Waterbury Health Network was held on Thursday, November 16, 2017 at Waterbury Hospital. That meeting was followed by a meeting for the Greater Waterbury community where information about the hospital's activities was shared and the public was encouraged to ask questions and provide comments. The meeting was advertised in the Waterbury Republican American on November 6 and November 13, 2017, and an article announcing the forum appeared in the Republican American on November 14.

If you have any questions or need anything further, please feel free to contact me at (203) 573-7101.

Very truly yours,

Peter Adamo
President & Chief Executive Officer
Waterbury Hospital/Greater Waterbury Health Network

Enclosures:
Community Forum ad in Republican American (11/6 and 11/13)
Business Brief from Republican American (11/14)
Presentation and agenda for the meeting
Sign-in sheets from the November 16 Forum
Republican American article about the Forum (11/17)

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consultant Partners, LLC
Von Crockett, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Appeared in Republican American
Monday, November 6
Monday, November 13

Community Forum

Learn more about Waterbury Hospital

Thursday, November 16, 2017 • 6:00 p.m. – 7:15 p.m.

Waterbury Hospital, Bizzozero Conference Room (4th floor), 64 Robbins Street, Waterbury

Waterbury Hospital/Greater Waterbury Health Network invite you to attend an upcoming community forum. During this event, you will learn how exciting new developments at our organization are strengthening the care you receive and how we are striving to improve the health and quality of life in our community.

Leaders from the Waterbury Hospital/Greater Waterbury Health Network will share the new initiatives taking place and will answer your questions.

Please join us for this forum and find out more about how we are working to shape the future of healthcare in our community.

WATERBURY HOSPITAL

Greater Waterbury Health Network

REPUBLICAN-AMERICAN TUESDAY, NOVEMBER 14, 2017

Business

DAILY BRIEFING

Waterbury Hospital to host community forum on Thursday

WATERBURY — Waterbury Hospital on Thursday is hosting it's second community forum.

The forums provide the hospital a chance to update the community on it's agenda and programs and to hear direct feedback from the community.

The forums are part of a state mandate attached to Prospect Mediccal Inc.'s acquisition of the hospital which requires the hospital to hold two forums per year. The last forum was held in May.

The meeting will be held at 6 p.m. in the hospital's Bizzozero Conference Room on the fourth floor.

Waterbury Hospital Community Forum

November 16, 2017

Greater Waterbury Health Network

WATERBURY HOSPITAL

Welcome and Introductions

Tonight's Agenda

- **Quality of Care Update: Drs. Cosgriff and Lundbye**
  - Focus on readmissions and strengthening culture of HRO
- **Investments: Dr. William Flynn**
  - $6.6 million OR instrumentation & equipment, IT infrastructure, imaging equipment, and numerous improvements throughout the hospital
- **Improvements in Patient Care: Dr. Ije Akunyili**
  - Reductions in door to provider times
  - ED expansion
- **Taking Care of Our Community: Patty Charvat**
  - 35,000 community members served
  - $21.4 million invested, $1 million - 5% - more than FY 2016
- **What's next: Mark Holtz**
  - Continued investment and improvements
- **Questions and Answers**

Waterbury HEALTH

Waterbury Hospital
Waterbury HEALTH

Access Rehab Centers
Waterbury HEALTH

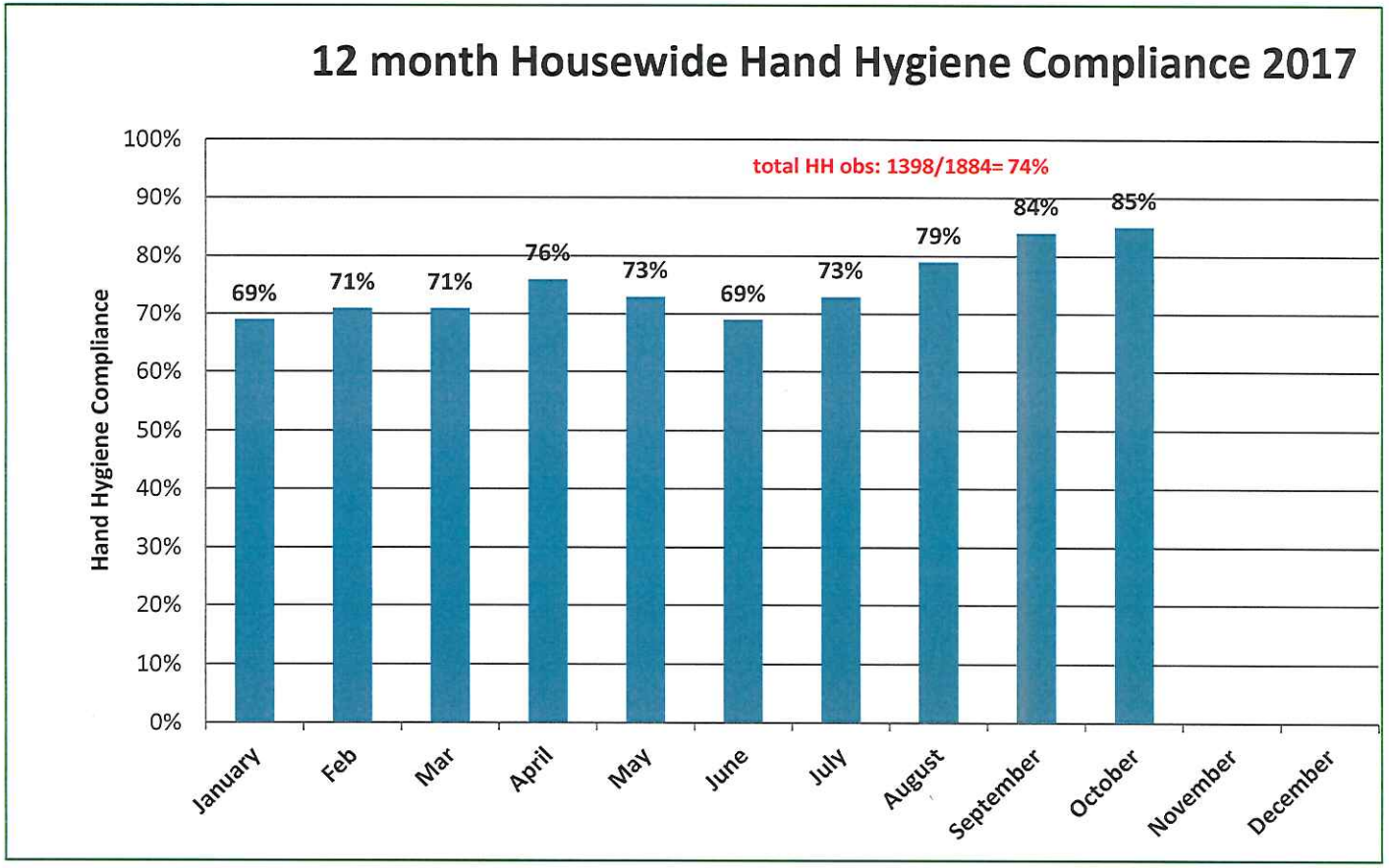
Cardiology Associates
Waterbury HEALTH

Alliance Medical Group
Waterbury HEALTH

VNA Health at Home
Waterbury HEALTH

Quality of Care Update: Dr. Joey Cosgriff

- **Decreasing Readmissions**
  - CHF clinic
  - Transition of care nurses
- **Improving the Patient Experience**
  - New multidisciplinary team
  - Focus on transition of care
- **Reducing Infections**
  - Significantly improving hand hygiene compliance
  - Zero infections in the ICU for 12 months & decrease in CLABSI and CAUTI
- **Improving opioid utilization**
  - Alternatives to non-opioid pain treatment
  - Ensuring appropriate use and dosage
- **Strengthening culture as a High Reliability Organization**
  - Feedback from employees and physicians to identify areas of improvement



Greater Waterbury Health Network

WATERBURY HOSPITAL

Recent awards

Waterbury Hospital: Top Honors

ONLY hospital in the State of CT to be named America's 100 Best for Coronary Intervention Procedures in 2018!!

PIONEERS IN QUALITY™

Greater Waterbury Health Network

WATERBURY HOSPITAL

Quality of Care Update: Dr. Justin Lundbye

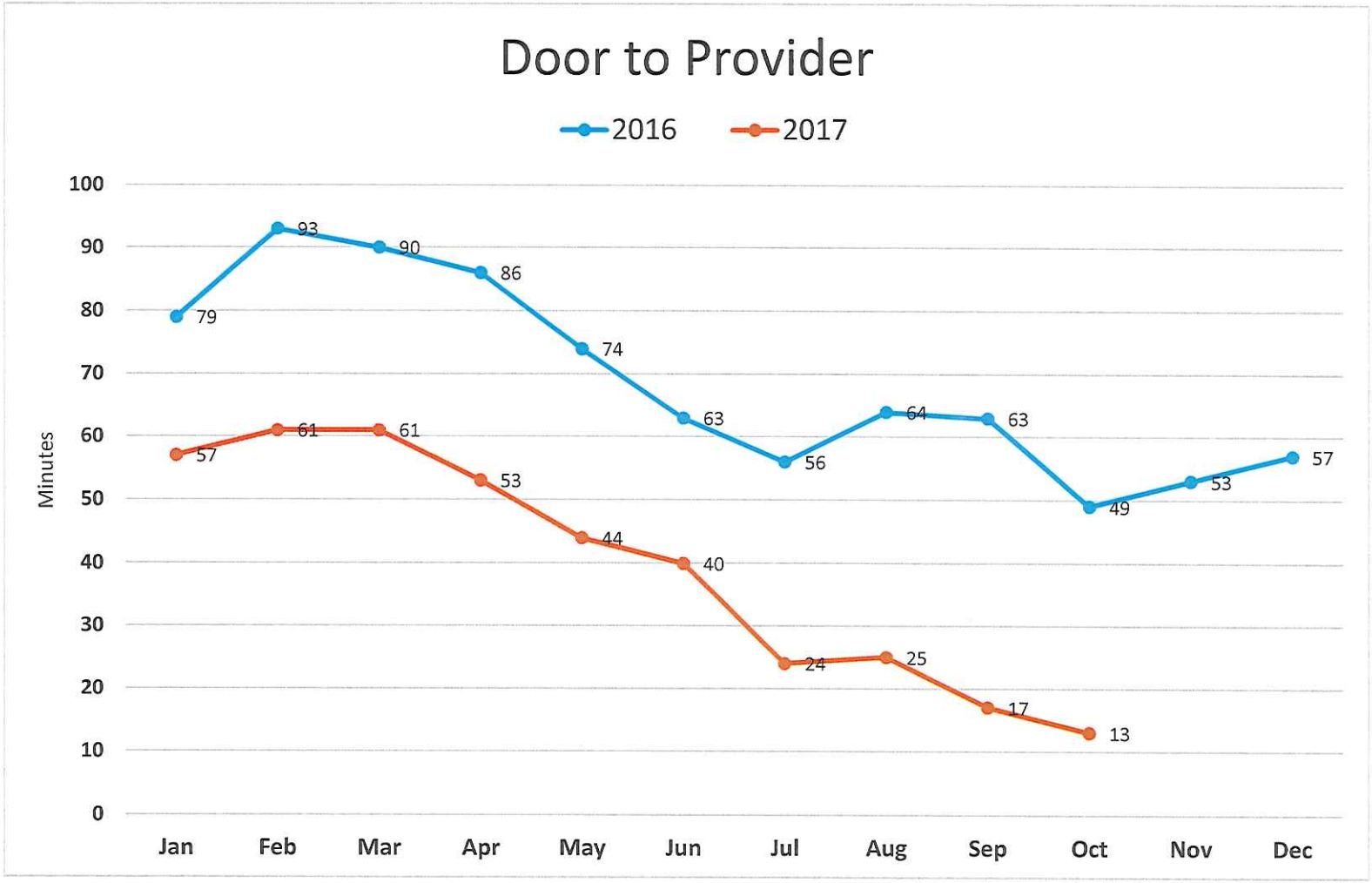
- **Decreasing Readmissions as a community**
  - Community Care Team development with Greater Waterbury Health Improvement Partnership
- **Focusing on stroke and trauma care**
  - Attaining certifications
- **Building innovative specialty centers**
  - Establishing colorectal surgery center
- **Strengthening physician retention**
  - Developed academic affiliation with Quinnipiac
- **Expanding cardiothoracic surgery capabilities**

Investments in patient care: Dr. William Flynn

- **Advanced orthopedic surgery equipment**
  - Leading-edge power tools for large and small bone surgeries
  - New lateral positioner for hip replacement surgeries
  - New mini C-Arm for hand and other upper/lower extremity surgeries
  - New fracture table, enables more efficient surgeries while maintaining patient safety
- **Waterbury Hospital's Center for Surgical Innovation**
  - Enhancements to the daVinci Xi Surgical Robotic System
  - Advanced operating room tables and lights and updated anesthesia equipment
- **New diagnostic equipment and technology**
  - Bladder scanner and ultrasound
  - Perinatal ultrasound
  - Probe for detailed, enhanced vascular studies
  - New EKG equipment
  - Portable X-ray equipment and testing
- **Substantial upgrading of information technology**

Improvements in Patient Care: Dr. Ije Akunyili

- Focus on improving performance of the Emergency Department
- Organizational effort that involves every department: lab, radiology, housekeeping, transport, patient floors, etc.
- Expanding and upgrading the Emergency Department


Door to Provider
2016
2017
Minutes
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17
13

Taking Care of Our Community: Patty Charvat

- Maintained the same charity care policy
- In FY2017, we provided $21 million in community benefit—$1 million more than in FY 2016
- Now paying more than $5M annually in new taxes to the City of Waterbury
- Expanded our community outreach initiatives, while losing grant funding and 340(b) funding ($2M) for medications for vulnerable patients

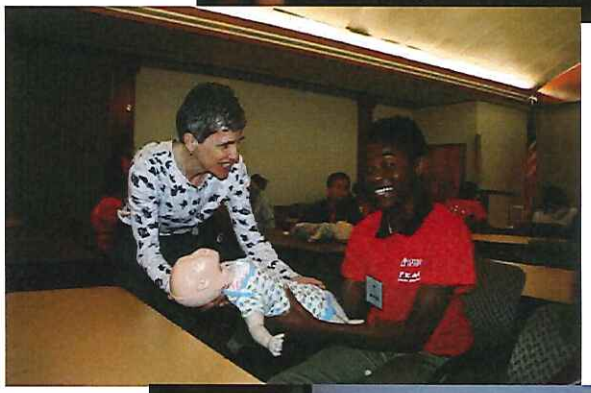
Greater Waterbury Health Network

WATERBURY HOSPITAL

Taking Care of Our Community: Programs

Traditional (Hospital)

- Youth Pipeline Initiatives (designed to build tomorrow's workforce)
  - Summer Bridge
  - PEACH
  - PEP Parent/Children Leadership Training Institute
- Waterbury Health Access Program (WHAP)
- Be Well Bus
- Evergreen 50 Club
- Numerous sponsorships and fundraising support



Taking Care of Our Community: Programs

New programs

- Diabetes Management, "Reinventing Banana Pudding" with inner city churches
- Fall Into/Spring Into Wellness series of health lectures, at hospital and in community
- Senior wellness fairs in communities around the region
- More than 60 programs and events during CY2017

Organizations supported by our employees

- Greater Waterbury Health Improvement Partnership
- Mayor's Drug Task Force
- Waterbury Development Corporation
- Boy Scouts
- Wolcott High School Robotic Team mentor
- Northfield Fire Company
- Litchfield County Fire Chiefs Board of Directors
- Connecticut Fire Chief Association
- North and South Foundation
- Pomperaug River Watershed Coalition
- CT Nurses Association
- Board of Finance, Morris, CT
- American Legion
- Stone Academy Academic Advisor
- Pomperaug Health District
- Waterbury Hospital Auxiliary Inc.
- Wolcott Board of Education
- Silas Bronson Library
- Rotary and Rotary International
- VFW
- Albanian/American Muslim Community

girls inc. Girls Incorporated of Western Connecticut

Waterbury Regional Chamber
driving business to business

75 YEARS United Way
United Way of Greater Waterbury

Acts 4 Ministry, Inc
Inspiring Acts of Love

St. Vincent DePaul
Mission of Waterbury

Greater Waterbury Interfaith Ministries, Inc.
GWIM All faiths, one mission.

Naugatuck Valley Community College

Greater Waterbury Health Network

WATERBURY HOSPITAL

What's next?

- Remodeling Labor & Delivery
- Opening a multi-specialty site in Southbury
- Continuing our renovations
- Working closely with ECHN, our sister hospital
- Continuing our outreach into the community
- Finding ways to keep the business local

Questions?

Waterbury Hospital Community Forum
Thursday, November 16, 2017

NAME	Contact Information
Stacey Addo	718-450-1252
Angela Fuoco	203-560-8235
Mickal Holmes	
LaTeena Bartee	203-560-9705
Jennie Lobegg	203-573-6530
Omar Shabazz	203-707-7336
Adeli Rodriguez	203-850-8822
Debbie DellaRocco	ODS
Tony Bacci	203-573-6721
Edith DaSilva	203-573-6231
Scott Bowman	203-720-0378
Bonnie & Ray Adams	203-754-6342
Brenda Morisette	
[illegible]	[illegible]
Sam Lombardi	203-573-7516
Susan Cordeiro	203-910-2086
Scott Kurtz	203 573-7257
Kim Kuklis	203 527-7107
Paul Galino	
Leslie Swidecki	203 573 7659

Waterbury Hospital Community Forum
Thursday, November 16, 2017

NAME	Contact Information
Natalie Cook	
Yanixa Lopez	
Colleen Smith	
Sandra Perez	
Evelyn Alejandro	WHAP (203) 573-6293
Reann Sahadeo	918-908-6023
Brandon Sahadeo	203-440-5937
Tiffany Batista	407 235 5565
Shinell DaCosta	917 204 0179
Sehgan Bhuna	
Brian Vaughn	203 558 3641
Carmen Silva	
Sue Marshall	
Cooper Nolan	
Mary Bradbury	
Eileen Woods	
Mary O'Hara	
Celeste Schmaltz	

Waterbury Hospital Community Forum
Thursday, November 16, 2017

NAME	Contact Information
Michele Valentino	—
Nicole Thomas	
Martha + Paul Thomas	
Joey Cosgrove	
Eriana Washington	
Monique Leach	
Pamela Barnes	
Carol Graham	
Pastor Shirley Brown CBCC of Waterbury	theholyone48@yahoo.com
Rev. Scott Nessel, St James, Southbury	
Kim McLaughlin	
JAZZ - Money Sykes	
Erica Clements	
Jeff Fraser	

Waterbury Hospital Community Forum
Thursday, November 16, 2017

NAME	Contact Information
DOROTHY FRITZELL	

HARRISON CONNERY REPUBLICAN-AMERICAN

The Rev. Ray Odiorne of the Naugatuck Valley Project reads a written statement to Waterbury Hospital CEO Peter Adamo. Rep Am 11/12/17

Waterbury Hospital lists improvements since sale

BY HARRISON CONNERY
REPUBLICAN-AMERICAN

WATERBURY—Waterbury Hospital held the second of its state mandated community forums Thursday night.

Peter Adamo, CEO, spoke in broad strokes to a packed conference room of about 75 people on the hospital's fourth floor about improvements to the hospital since it was acquired by Prospect Medical Holdings, Inc. last year. He left the details to his physicians who spoke of the improved quality of care, investments in equipment and infrastructure totaling over $6 million, and community outreach.

According to Hospital Spokeswoman Patricia Charvat, the hospital invested $21 million in the local care, investments in equip-

See **HOSPITAL**, *Page* **5B**

HOSPITAL: Paid $5M in taxes

ment and infrastructure totaling over $6 million, and community outreach.

According to Hospital Spokeswoman Patricia Charvat, the hospital invested $21 million in the local community in fiscal year 2017, $1 million more than the year before, and paid $5 million in annual taxes from which it was exempt when it was a nonprofit institution. She said the hospital hosted more than 60 community outreach programs this calendar year.

The theme throughout the night was the improved patient care at the hospital as a result of new staff initiatives and equipment. Dr. Joey Cosgriff said the number of patient readmissions is down thanks in part to a growing congestive heart failure clinic, and transition-of-care nurses who see patients before their discharge to make sure they understand their care to facilitate the transition home or to an outpatient care facility. There have been no infections caused by stays in the Intensive Care Unit in the last year, which has helped lower readmissions.

"We have had a campaign that is related to hand hygiene making sure that all of our providers wash their hands when they go in and out of the room, that's the thing that decreases infection most," she said. "We just heard a story at the board where we actually are having staff members mention to physicians if they're not washing their hands, so that's a culture change here."

Massive improvements have been made to the emergency department, said Dr. Ije Akunyili. Door-to-provider wait times have been cut to 10 to 13 minutes and patients' length of stays are below the national average.

"This is record breaking," said Akunyili. "Industry standard is about 20 minutes. Our goal is that sometime in the not too distant future 100 percent of our patients will be seen in 10 minutes of arrival to the emergency room."

She said that fewer than 1 percent of emergency department patients leave before being treated.

The hospital has made investments in new equipment for orthopedic surgery, anesthesia, bladder scans and ultrasounds, perinatal ultrasounds, probes for vascular studies, EKGs and X-Rays.

Community members who benefited from the hospital's charitable initiatives and student development programs were on hand to vocalize their appreciation. Waterbury Hospital runs several programs to serve local middle and high school students.

Leaders of the Naugatuck Valley Project questioned Adamo on the hospital's corporate structure and if its commitments to the community will continue after the terms and conditions the Connecticut Office of Health Care Access imposed on Prospect expire in 2019.

Rev. Dr. Ray Odiorne read a letter addressed to Adamo from the NVP accusing the hospital of not doing enough to promote news of the meeting to suppress community turn out.

"We want transparency, we want honesty," said Odiorne, who invited Adamo and other board members to meet with his group in January. A prior meeting between Adamo and members of the NVP in September ended abruptly when Adamo felt the topic of staffing ratios encroached on confidential union negotiations.

Brenda Morisette, a member of the NVP's executive board and a retired Waterbury Hospital employee of 32 years, said that the public had a right to know about staffing ratios as it affects patient care.

Odiorne acknowledged that many of his initial concerns were addressed by the forum.

The first forum was held in May.

User, OHCA

From: Buckley, Katherine <kBuckley@wtbyhosp.org>
Sent: Friday, January 05, 2018 2:15 PM
To: User, OHCA
Cc: Martone, Kim; colleen713.smith@gmail.com; Garrison De Lee (Legal Department) (Garrison.DeLee@prospectmedical.com); Frank.Saidara@prospectmedical.com; Shin, Ellen (ellen.shin@prospectmedical.com); Roberts, Karen; Adamo, Peter; Golino, Paul
Subject: Docket Number 15-32017-486-CON
Attachments: Docket Number 15-32017-486-CON OHCA Condition Numbers EIght Nine and Ten (April to Sept17 Reporting).pdf

Attached is the semi-annual submission related to condition numbers Eight (8), Nine (9), and Ten (10) for the above referenced Certificate of Need Final decision regarding the transfer of assets of Greater Waterbury Health Network to Prospect Medical Holdings, Inc.

Katherine Buckley-Finance Department
Waterbury Hospital

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Waterbury HEALTH

January 3, 2018

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Docket Number: 15-32017-486

Project Title: Transfer of assets of Greater Waterbury Health Network to Prospect Medical Holdings, Inc.

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Eight (8), Condition Number Nine (9) and Condition Number Ten (10) regarding the transfer of assets of Greater Waterbury Health Network (now called Waterbury HEALTH) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Eight (8) requires that on a semi-annual basis until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New Waterbury Hospital/Waterbury HEALTH and its affiliates from the $55 million Commitment Amount. Please find the Capital Investment Report for the second half of Fiscal Year 2017 labeled as Exhibit A. In addition, please find Exhibit B which includes current planned capital needs for the upcoming Fiscal Year 2018. The exhibits contain the following information:

a. The capital expenditures that have been made in the second half of Fiscal Year 2017, with description of each associated project ; and
b. An explanation as to why each expenditure was made.

Condition Number Nine (9) requires that PMH provide a report for New Waterbury Hospital/Waterbury HEALTH on a semi-annual basis with the following information:

64 Robbins Street, Waterbury, CT 06708 • (203) 573-6000 • www.waterburyhospital.org

a) The cost saving totals achieved in the following Operating Expense Categories for New Waterbury Hospital/Waterbury HEALTH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses, and other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

   1. The major cost savings achieved for each expense category for the semi-annual period; and
   2. The effect of cost savings on the clinical quality of care.

b) A Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New Waterbury Hospital/Waterbury HEALTH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

For Condition Number Nine (9.a.), please find Exhibit C which shows the expenses by category using the form of HRS Report 175 for the period of April 1, 2017 through September 30, 2017 as compared to the first half of Fiscal Year 2017, October 1, 2016 through March 31, 2017. Exhibit D contains information relating to the clinical quality of care provided at Waterbury Hospital/Waterbury HEALTH this past year.

For Condition Number Nine (9.b.), please find Exhibit E using the form of HRS Reports 100/150 and 300/350 which includes the Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New Waterbury Hospital/Waterbury HEALTH.

Condition Number Ten (10) requires that on a semi-annual basis, PMH provide a report for New Waterbury Hospital/Waterbury HEALTH with the following financial measurements/indicators showing current month and year-to-date data and comparable prior year period data for New Waterbury Hospital/Waterbury HEALTH:

Financial Measurement/Indicators

A. Operating Performance
   1. Operating Margin
   2. Non-Operating Margin
   3. Total Margin

B. Liquidity
   1. Current Ratio
   2. Days Cash on Hand
   3. Days in Net Accounts Receivables
   4. Average Payment Period

C. Leverage and Capital Structure
   1. Long-term Debt to Equity
   2. Long-term Debt to Capitalization
   3. Unrestricted Cash to Debt
   4. Times Interest Earned Ratio
   5. Debt Service Coverage Ratio
   6. Equity Financing Ratio

D. **Additional Statistics**
   1. Income from Operations
   2. Revenue Over/(Under) Expense
   3. Cash from Operations
   4. Cash and Cash Equivalents
   5. Net Working Capital
   6. Free Cash Flow (and the elements used in the calculation)
   7. Unrestricted Assets/Retained Earnings
   8. Bad Debt as % of Gross Revenue
   9. Credit Ratings (S&P, FITCH, or Moody's)

Please find Exhibit F for the periods beginning on April 1, 2017 through September 30, 2017 showing current month and year to date measurements as required for Condition Ten (10). Future reports will compare the data to the comparable period for the prior year.

If you have any questions or need anything further, please feel free to contact me at 203-573-7280. .

Very truly yours,

Paul Golino
Chief Financial Officer
Waterbury Hospital/Waterbury HEALTH

Enclosures:

Exhibit A- Condition Number Eight (8) - Capital Investment Report
Exhibit B – Condition Number Eight (8) – Fiscal Year 2018 Planned Capital Expenditures
Exhibit C – Condition Number Nine (9.a) - Expenses by Category
Exhibit D – Condition Number Nine (9.a) – Effect of Cost Savings on Clinical Quality of Care
Exhibit E – Condition Number Nine (9.b.) - Consolidated Balance Sheets, Statements of Operations, and Statements of Cash Flows for New Waterbury Hospital/Waterbury Health
Exhibit F – Condition Number Ten (10) - Current Month and Year to Date Measurements

cc: Kimberly R. Martone, Director of Operations, Office of Health Care Access, Connecticut Department of Public Health
Karen Roberts, Principal Health Care Analyst, Office of Health Care Access, Connecticut Department of Public Health
Colleen Smith, Nursing Consultant Partners, LLC
Peter Adamo, Waterbury Hospital/Waterbury HEALTH
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc

EXHIBIT A

Prospect Waterbury, Inc
Capital Investment Report
Paid Capital-April 2017 to Sept 2017

Fiscal Year	Fiscal Quarter	Item Description	Justification	Cost
2017	Quarter 3	Cart Washer	Replacement	167,108.82
2017	Quarter 3	Hospital Signage	Replacement	111,824.41
2017	Quarter 3	BH POS Cash	Repair Upgrade	21,382.15
2017	Quarter 3	OR Storage Cabinets	Replacement	88,731.35
2017	Quarter 3	CS Air Handler BL #1	Replacement	65,267.40
2017	Quarter 3	FBC Surgical Lights	Replacement	52,151.60
2017	Quarter 3	OR Surgical Lights	Replacement	78,062.00
2017	Quarter 3	Strain/4D upgrade	New equipment in outpatient area to provide new testing services to patients	$2,687.48
2017	Quarter 3	Washable Keyboards for COWs	Infection control issue for the WOWs	$2,469.45
2017	Quarter 3	Anorectal Probe	New equipment to expand service in urology for prostate cancer	$48,268.69
2017	Quarter 3	CAGW Telephone System	Upgraded and replaced aged equipment	$66,195.66
2017	Quarter 3	Chase Telephone System	Upgraded and replaced aged equipment	$9,778.68
2017	Quarter 3	125 WOW Laptop Adapters	Upgraded and replaced aged equipment to ensure nursing can do bedside work	$3,697.39
2017	Quarter 3	iAccess Implementation	Ability for providers to have a single sign on when working in the EMR	$99,756.30
2017	Quarter 3	25 Additional Med Carts	Upgraded and replaced aged equipment for our nursing team for medication management	$133,914.59
2017	Quarter 3	Neopuff	Added equipment for neonatal resuscitation that OB did not have previously	$2,312.81
2017	Quarter 3	CAGW UPS Battery Replacement	Upgraded and replaced aged equipment	$2,744.99
2017	Quarter 3	CR to DR Ultrasound Unit	Part of a multi year project to enhance imaging equipment to digital	$211,492.00
2017	Quarter 3	OPMT Recliners	Upgraded and replaced aged recliners for our patients who require infusions	$14,180.15
2017	Quarter 3	Stretchers	Upgraded and replaced aged equipment	$56,950.43
2017	Quarter 3	Bladder Scanner	New equipment for our nursing units each unit will have their own versus sharing with the ED	$19,303.13
2017	Quarter 3	Rooftop Sign - LED upgrade	Current sign was an old neon gas and not able to replace several letters were out	$25,258.00
2017	Quarter 3	Architectural Fees for GI Move	Moving GI closer proximity to the Surgical Services area and readying this space for the wound care center	$28,980.38
2017	Quarter 3	Monitors for WOWs	Upgraded and replaced with new equipment larger screens for nursing	$18,207.12
2017	Quarter 3	Telepsychiatry Telehealth Evaluation - Ipads (4)	Behavioral Health Physicians and staff will have the ability to provide telehealth services	$7,956.00
2017	Quarter 4	FBC Gynnie Stretcher	Upgraded and replaced aged equipment with new	$5,542.96
2017	Quarter 4	Ascom Phone Upgrade - Telemetry	Upgraded and replaced aged equipment with new for the clinical staff for purposes of communication	$8,605.84
2017	Quarter 4	All-in-One Computers for AMG	Upgraded and replaced aged equipment with new	$6,695.48
2017	Quarter 4	Omnibed Carestation	Upgraded and replaced aged equipment with new for the OS program	$53,637.95
2017	Quarter 4	Closed Loop Door Operator - Elevators - 1 unit	Upgraded and replaced aged equipment	$17,115.47
2017	Quarter 4	Closed Loop Door Operator - Elevators - 5 units	Upgraded and replaced aged equipment	$85,577.35
2017	Quarter 4	Elevators, Closed Loop Door Operator Install (0)	Upgraded and replaced aged equipment	$96,561.20
2017	Quarter 4	Laptop - C. Brubaker	Upgraded and replaced laptop with new	$1,014.04
2017	Quarter 4	PACS upgrade	Upgrade of the radiology PACS System	$61,151.25
2017	Quarter 4	Exterior Restoration Main Building	Cleaning of marble and painting of exterior	$174,245.00
2017	Quarter 4	Sternal Saws	Provided new equipment to OR for cardiothoracic program	$10,343.49
2017	Quarter 4	Tivoli Support Reinstatement	IT Software and backup system installed	$68,397.73
2017	Quarter 4	IT Laptops (4) and Docking Station (1)	Computer inventory for system	$3,693.54
2017	Quarter 4	IT Monitors (30)	IT inventory for system	$4,466.70
2017	Quarter 4	IT POS Units (25)	IT inventory for system	$19,834.28
2017	Quarter 4	Cepheid Equipment	New lab service with ability to screen patients for C-Diff (Infection Control)	$89,319.20
2017	Quarter 4	Window RenovaSons - Merriman Hall	Replacement with new for old windows	$24,394.56
2017	Quarter 4	Freezer, Ultra Low Tissue Storage	Lab services for pathology replacement with new	$11,324.99
2017	Quarter 4	BH TV, Computers, etc.	Upgraded and replaced with new for POM & BH Inpatient Unit	$1,480.24
2017	Quarter 4	OR Tables - Bariatric	Upgraded and replaced with new equipment for Bariatric Program	$99,321.07
2017	Quarter 4	Folding Chairs - Critical Care	Visitor chairs	$4,472.00
2017	Quarter 4	ICU Waiting Room Furniture	Replacement for new furniture for visitors (family waiting room)	$19,416.74
2017	Quarter 4	IT Data Center Uplift	Upgraded and replaced with new to ensure IT infrastructure is stable	$571,830.15
2017	Quarter 4	Data Center re-architect	Upgraded and replaced with new to ensure IT infrastructure is stable	$671,951.36
2017	Quarter 4	Bar Code Scanners (4)	New equipment for medication administration	$2,884.21
2017	Quarter 4	IT Network Uplift	Preparation of the CERNER EMR System Code Upgrade	$182,751.41
2017	Quarter 4	Network CORE re-architect	Upgraded and replaced with new to ensure IT infrastructure is stable	$148,169.41
2017	Quarter 4	Sidewalk Replacement	Current sidewalk cement was crumbling and a danger to visitors	$33,968.19
2017	Quarter 4	GI Motorized Endoscopy Cart	Current equipment was difficult to move and posed a danger to employees	$6,624.62
2017	Quarter 4	IT Laptops for stock - quantity of 5	IT inventory for system	$4,466.70
2017	Quarter 4	North Four Carpeting	Replacement to new of carpeting for the Finance Department	$32,436.75
2017	Quarter 4	Portable XRAY Units	Multi-year plan to upgrade all imaging equipment to digital	$296,716.50
2017	Quarter 4	Merriman Hall Security	Enhancement of the front end registration area for employee safety	$44,376.08
				$4,313,137.46

Exhibit B

GWHN Planned Capital Needs
for FY 2018
(as of Nov 2017)

General Department	Specific Department	Item/Investment	Total Cost
Diagnostic Imaging	Cardiology	EKG Machines	$261,069
Surgical Services	OR	Anesthesia Machines	$471,969
Nursing Unit	OB	Uplift/Renovation	$600,000
Emergency Department	ED	Renovation	$5,000,000
All Other	AMG	Southbury MOB	$406,000
Plant Operations	Facilities	Physician Lounge	$55,552
Plant Operations	Facilities	Parking Lot Guard Rail	$47,000
All Other	BH Outpatient	Chairs	$15,000
Lab	Serology	Vidas	$5,500
All Other	Hospital	Furniture	$50,000
Information Services(IT)	IT	Infrastructure Replacement	$616,000
All Other	Wound Care	Construction Wound Care	$350,000
Nursing Unit	OB	Fetal Monitor	$145,000
Plant Operations	Facilities	Roofing	$325,512
Plant Operations	Facilities	Pomeroy Building Exterior	$528,800
Plant Operations	Facilities	Air Handler Replacements	$1,655,520
Plant Operations	Facilities	Absorption Chiller Replacement	$822,000
Plant Operations	Facilities	Elevators	$300,000
Plant Operations	Facilities	Parking Lots/Driveways	$282,190
Plant Operations	Facilities	Building Up Lighting	$30,000
Diagnostic Imaging	Medical Imaging	Siemens Symbia Dual Head Camera	$276,358
Diagnostic Imaging	Medical Imaging	Diagnostic Room #9 Renovations	$250,000
Diagnostic Imaging	Medical Imaging	Intervention Radiology Suite Renovation	$750,000
Diagnostic Imaging	Medical Imaging	Ultrasound Units (4)	$200,000
Diagnostic Imaging	Medical Imaging	Lead Shield Replacement	$5,000
Diagnostic Imaging	Medical Imaging	CT Dual Head Injector	$50,000
Diagnostic Imaging	Medical Imaging	Mobile C-Arm (3)	$175,000
Administration	Administration	AV Equipment Upgrade	$30,000
Nursing Unit	Various	Patient Beds	$480,000
Nursing Unit	Various	Nurse Call System	$384,580
Nursing Unit	Various	Defibrillator	$410,000
Nursing Unit	Various	Patient Televisions	$130,000
All Other	Chase Clinic	Flooring	$49,490
All Other	Chase Clinic	Painting	$60,000
Lab	Microbiology	Bactec	$7,720
Lab	Microbiology	Microscopes (4)	$15,000
Lab	Microbiology	Centrifuge	$7,500
Lab	Point of Care	Hemochron (4)	$33,180
Lab	Point of Care	Driver to Telcor	$15,000
Lab	Chemistry	Stat Spin (ABGs)	$3,000
Lab	Chemistry	Atlas Urinalysis Instrument	$60,000
Lab	Chemistry	Freezers (2) Lab Grade	$15,000
Lab	Hematology	Instruments	$350,000
Lab	Hematology	Slide Stainer	$13,000
Lab	Blood Bank	ProVue	$125,000
Lab	Blood Bank	Cell Washer	$10,000
Lab	Blood Bank	Equipment	$5,000
Lab	Blood Bank	Immufuges (3)	$10,000
Lab	Serology	Equipment	$2,000
Lab	Anatomic Pathology	Tissue Processor	$60,000
Lab	Anatomic Pathology	Color Printers (3)	$8,000
Lab	Anatomic Pathology	Microtomes	$12,000
Lab	Anatomic Pathology	Equipment	$5,000
Total			$16,167,940

Exhibit C
Prospect Waterbury, Inc.
Report 175-Operating Expenses by Category
Comparison: October 2016 to March 2017 and April 2017 to Sept 2017

	Oct to Mar 17	Apr to Sept 17	Total FY 2017
A-Salary	$41,248,305	$39,173,117	$80,421,422
B-Fringes	$12,496,525	$11,027,639	$23,524,164
C-Contracted Labor	$4,706,266	$4,174,954	$8,881,220
D-Supplies/Drugs	$15,310,701	$15,677,650	$30,988,351
E-Depreciation	$3,079,500	$3,079,500	$6,159,000
F-Bad Debts	$0	$0	$0
G-Interest	$633,140	$623,312	$1,256,453
H-Malpractice	$2,682,654	$1,081,863	$3,764,517
I-Utilities	$1,665,302	$1,692,705	$3,358,007
J-Business Expenses	$17,955,486	$20,559,283	$38,514,769
K-Other Operating Expenses	$3,089,327	$3,006,172	$6,095,499
	$102,867,206	**$100,096,195**	**$202,963,401**

Exhibit D

Waterbury Hospital

Quality Metric	2016	2017	Change
Overall Infection Rate	NA	NA	NA
Surgical Site Infection Rate	NA	NA	NA
Abd Hysterectomy SSIs Per 100 cases (# cases)	0/30=0%	026=0%	0
Total Hip and Knee Infections Per 100 cases (# cases)	5/511=0.98%	2/488=0.41%	-0.57
C-Section Infections	NA	NA	NA
C-diffle Rate (per 1000 pt days, exc. BH)	0.58	0.46	-0.12
CLABSI, ICU per 1000 catheter days (# cases)	1.86 (6)	0.33 (1)	-1.53 (-5)
CLABSI, Non-ICU per 1000 catheter days (# cases)	1.65 (8)	0.70 (3)	-0.95 (-6)
CAUTIs, ICU (# cases)	2.48 (6)	0.40 (1)	-2.08 (-5)
CAUTIs, Non-ICU (# cases)	1.61 (6)	1.71 (6)	0.1 (0)
Hospital Wide 30 day Readmission Rates FY data. (FY 17 through July)	10.8%	10.8 %	0
Penalty Rates (readmissions)	0.73%	1.04%	0.31

Exhibit E

PROSPECT WATERBURY INC.

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(4)
		Sept 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$778,454
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$29,688,229
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$1,128,784
6	Due From Third Party Payers	$2,455,418
7	Inventories of Supplies	$3,370,466
8	Prepaid Expenses	$3,433,254
9	Other Current Assets	$832,363
	Total Current Assets	**$41,686,968**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$12,290,999
7	Other Noncurrent Assets	$169,601
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$279,452,435
2	Less: Accumulated Depreciation	$255,232,526
	Property, Plant and Equipment, Net	**$24,219,909**
3	Construction in Progress	$324,848
	Total Net Fixed Assets	**$24,544,757**
	Total Assets	**$78,692,325**

Exhibit E

PROSPECT WATERBURY INC.		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(4)
LINE	DESCRIPTION	Sept 2017 ACTUAL
II.	LIABILITIES AND NET ASSETS	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$22,819,300
2	Salaries, Wages and Payroll Taxes	$2,908,528
3	Due To Third Party Payers	$0
4	Due To Affiliates	$0
5	Current Portion of Long Term Debt	$0
6	Current Portion of Notes Payable	$711,334
7	Other Current Liabilities	$0
	Total Current Liabilities	**$26,439,162**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$1,199,158
	Total Long Term Debt	**$1,199,158**
3	Accrued Pension Liability	$0
4	Other Long Term Liabilities	$14,182,174
	Total Long Term Liabilities	**$15,381,332**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	$36,871,831
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**$36,871,831**
	Total Liabilities and Net Assets	**$78,692,325**

Exhibit E

PROSPECT WATERBURY INC.

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
LINE	DESCRIPTION	OCT - MAR 17 ACTUAL	APR - SEP17 ACTUAL	YTD SEPT 17 ACTUAL
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$448,713,287	$450,969,319	$899,682,606
2	Less: Allowances	$333,827,114	$331,640,249	$665,667,363
3	Less: Charity Care	$3,686,190	3,154,861	$6,841,051
4	Less: Other Deductions	$6,210,700	$7,465,653	$13,676,353
	Total Net Patient Revenue	**$104,989,283**	**$108,508,556**	**$213,497,839**
5	Provision for Bad Debts	($177,507)	($394,409)	($571,916)
	Net Patient Service Revenue less provision for bad debts	**$105,166,790**	**$108,902,965**	**$214,069,755**
6	Other Operating Revenue	$2,056,285	$969,679	$3,025,964
7	Net Assets Released from Restrictions	$1,306,157	$1,733,337	$3,039,494
	Total Operating Revenue	**$108,529,232**	**$111,605,981**	**$220,135,213**
B.	**Operating Expenses:**			
1	Salaries and Wages	$41,248,306	39,173,117	$80,421,423
2	Fringe Benefits	$12,496,525	11,027,639	$23,524,164
3	Physicians Fees	$3,866,200	4,154,151	$8,022,351
4	Supplies and Drugs	$15,310,702	15,677,650	$30,988,352
5	Depreciation and Amortization	$3,079,500	3,079,500	$6,159,000
6	Bad Debts	$0	0	$0
7	Interest Expense	$633,140	623,312	$1,256,452
8	Malpractice Insurance Cost	$2,682,654	1,081,863	$3,764,517
9	Other Operating Expenses	$23,548,179	25,278,963	$48,827,142
	Total Operating Expenses	**$102,867,206**	**$100,096,195**	**$202,963,401**
	Income/(Loss) From Operations	**$5,662,026**	**$11,509,786**	**$17,171,812**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$0	$0	$0
2	Gifts, Contributions and Donations	$0	$0	$0
3	Other Non-Operating Gains/(Losses)	$0	$0	$0
	Total Non-Operating Revenue	**$0**	**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$5,662,026**	**$11,509,786**	**$17,171,812**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	$0	$0
	All Other Adjustments	$0	$0	$0
	Total Other Adjustments	**$0**	**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**$5,662,026**	**$11,509,786**	**$17,171,812**
	Principal Payments	$1,348,691	$360,307	$1,708,998

Exhibit E

GREATER WATERBURY HEALTH NETWORK
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(4)
		Sept 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$7,372,971
2	Short Term Investments	$584,520
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$39,177,208
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$0
6	Due From Third Party Payers	$2,455,418
7	Inventories of Supplies	$3,624,919
8	Prepaid Expenses	$4,150,292
9	Other Current Assets	$1,844,577
	Total Current Assets	**$59,209,905**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$12,383,906
7	Other Noncurrent Assets	$233,493
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$294,325,947
2	Less: Accumulated Depreciation	$266,830,034
	Property, Plant and Equipment, Net	**$27,495,913**
3	Construction in Progress	$324,848
	Total Net Fixed Assets	**$27,820,761**
	Total Assets	**$99,648,065**

Exhibit E

GREATER WATERBURY HEALTH NETWORK
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(4)
		Sept 2017
LINE	DESCRIPTION	ACTUAL
II.	LIABILITIES AND NET ASSETS	
A.	Current Liabilities:	
1	Accounts Payable and Accrued Expenses	$26,954,372
2	Salaries, Wages and Payroll Taxes	$4,938,515
3	Due To Third Party Payers	$300,000
4	Due To Affiliates	$10,572,308
5	Current Portion of Long Term Debt	$14,965
6	Current Portion of Notes Payable	$717,632
7	Other Current Liabilities	$117,618
	Total Current Liabilities	**$43,615,410**
B.	Long Term Debt:	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$1,199,158
	Total Long Term Debt	**$1,199,158**
3	Accrued Pension Liability	$0
4	Other Long Term Liabilities	$14,182,174
	Total Long Term Liabilities	**$15,381,332**
5	Interest in Net Assets of Affiliates or Joint Ventures	$2,834,849
C.	Net Assets:	
1	Unrestricted Net Assets or Equity	$37,816,474
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**$37,816,474**
	Total Liabilities and Net Assets	**$99,648,065**

Exhibit E

GREATER WATERBURY HEALTH NETWORK

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	(5)
LINE	DESCRIPTION	OCT-MAR ACTUAL	APR - SEP ACTUAL	YTD SEPT 17 ACTUAL
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$499,814,837	$500,625,759	$1,000,440,596
2	Less: Allowances	$358,232,236	$356,099,935	$714,332,171
3	Less: Charity Care	$3,686,190	$3,154,861	$6,841,051
4	Less: Other Deductions	$6,210,700	$7,465,653	$13,676,353
	Total Net Patient Revenue	**$131,685,711**	**$133,905,310**	**$265,591,021**
5	Provision for Bad Debts	$1,199,508	($71,297)	$1,128,211
	Net Patient Service Revenue less provision for bad debts	**$130,486,203**	**$133,976,607**	**$264,462,810**
6	Other Operating Revenue	$5,287,137	$4,253,684	$9,540,821
7	Net Assets Released from Restrictions	$1,464,288	$2,673,603	$4,137,891
	Total Operating Revenue	**$137,237,628**	**$140,903,894**	**$278,141,522**
B.	**Operating Expenses:**			
1	Salaries and Wages	$64,753,540	$63,688,688	$128,442,228
2	Fringe Benefits	$16,140,047	$14,575,679	$30,715,726
3	Physicians Fees	$4,438,933	$5,662,221	$10,101,154
4	Supplies and Drugs	$16,359,131	$16,550,812	$32,909,943
5	Depreciation and Amortization	$3,434,898	$3,552,994	$6,987,892
6	Bad Debts	$0	$0	$0
7	Interest Expense	$634,281	$624,046	$1,258,327
8	Malpractice Insurance Cost	$3,363,317	$1,633,167	$4,996,484
9	Other Operating Expenses	$28,690,065	$30,172,253	$58,862,318
	Total Operating Expenses	**$137,814,212**	**$136,459,860**	**$274,274,072**
	Income/(Loss) From Operations	**($576,584)**	**$4,444,034**	**$3,867,450**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$0	$0	$0
2	Gifts, Contributions and Donations	$0	$0	$0
3	Other Non-Operating Gains/(Losses)	($354,985)	($383,872)	($738,857)
	Total Non-Operating Revenue	**($354,985)**	**($383,872)**	**($738,857)**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($931,569)**	**$4,060,162**	**$3,128,593**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	$0	$0
	All Other Adjustments	$0	$0	$0
	Total Other Adjustments	**$0**	**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($931,569)**	**$4,060,162**	**$3,128,593**

EXHIBIT E

Waterbury Hospital
Statement of Cash Flows
4/1/17 through 9/30/17

Net Income/(Loss)	11,509,786
Adjustments to reconcile net income/(loss) to net cash (used in)/provided by operating activities and nonoperating revenues:	
Provision for bad debt	(394,409)
Depreciation and amortization	3,079,500
	14,194,877
Changes in operating working capital other than cash and cash equivalents:	
Patient accounts receivable (net)	1,927,927
Grants and other receivables	(113,723)
Inventory of supplies	(127,599)
Prepaid insurance and other expenses	(1,164,284)
Accounts payable and accrued expenses	2,470,743
Salaries, wages, payroll taxes and amounts withheld from employees	(25,597)
Due to restricted funds	(545,833)
Other noncurrent liabilities	447,882
Due to 3rd party reimbursement agencies	(5,659,805)
	(2,790,289)
Net cash (used in)/provided by operating activities and nonoperating gains	11,404,588
Investing activities:	
(Increase)/decrease in due from affiliates	(5,967,061)
Decrease/(increase) in other assets	(480,438)
Additions to property, plant and equipment	(3,727,299)
Net cash (used by)/provided by investing activities	(10,174,798)
Financing activities:	
Proceeds from issuance of debt	0
Principal payments on debt obligations	(361,964)
Net cash (used in)/provided by financing activities	(361,964)
Net increase/(decrease) in cash and cash equivalents	867,826
Cash and cash equivalents at beginning of period	(89,372)
Cash and cash equivalents at end of period	778,454

EXHIBIT E

Greater Waterbury Health Network
Statement of Cash Flows
4/1/17 through 9/30/17

Net Income/(Loss)	4,060,162
Adjustments to reconcile net income/(loss) to net cash (used in)/provided by operating activities and nonoperating revenues:	
Provision for bad debt	(71,297)
Depreciation and amortization	3,552,994
	7,541,859
Changes in operating working capital other than cash and cash equivalents:	
Patient accounts receivable (net)	1,381,366
Grants and other receivables	(421,593)
Inventory of supplies	(85,008)
Prepaid insurance and other expenses	(1,136,478)
Accounts payable and accrued expenses	4,523,267
Salaries, wages, payroll taxes and amounts withheld from employees	(21,186)
Due to restricted funds	(545,833)
Other noncurrent liabilities	13,660
Due to 3rd party reimbursement agencies	(5,659,805)
	(1,951,610)
Net cash (used in)/provided by operating activities and nonoperating gains	5,590,249
Investing activities:	
(Increase)/decrease in due from affiliates	1,538,809
Decrease/(increase) in other assets	(481,306)
Additions to property, plant and equipment	(3,865,947)
Net cash (used by)/provided by investing activities	(2,808,444)
Financing activities:	
Proceeds from issuance of debt	0
Principal payments on debt obligations	(378,411)
Net cash (used in)/provided by financing activities	(378,411)
Net increase/(decrease) in cash and cash equivalents	2,403,394
Cash and cash equivalents at beginning of period	5,554,097
Cash and cash equivalents at end of period	7,957,491

Exhibit F

PROSPECT WATERBURY INC.

REPORT 385 - HOSPITAL CONSOLIDATED FINANCIAL DATA ANALYSIS

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
LINE	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
1	Total Gross Revenue	$72,605,707	$78,445,779	$77,192,308	$72,554,611	$76,364,840	$73,806,074	$521,318,994	$599,764,773	$676,957,081	$749,511,692	$825,876,532	$899,682,606
2	Total Allowances	$54,975,781	$59,788,369	$59,015,412	$55,314,392	$58,237,023	$55,129,785	$398,699,785	$458,488,154	$517,503,566	$572,817,958	$631,054,981	$686,184,766
3	Bad Debt	$550,213	$518,812	$544,295	$593,667	$977,170	($3,578,567)	$372,706	$891,518	$1,435,813	$2,029,480	$3,006,650	($571,917)
4	Net Patient Revenue/Total Operating Revenue	$17,079,713	$18,138,598	$17,632,601	$16,646,552	$17,150,647	$22,254,856	$122,246,503	$140,385,101	$158,017,702	$174,664,254	$191,814,901	$214,069,757
5	Total Operating Expenses	$16,464,171	$16,654,393	$15,792,183	$15,441,178	$16,122,798	$15,918,661	$115,618,737	$132,273,130	$148,065,313	$163,506,491	$179,629,289	$195,547,950
6	Income/(Loss) From Operations	$615,542	$1,484,205	$1,840,418	$1,205,374	$1,027,849	$6,336,195	$6,627,766	$8,111,971	$9,952,389	$11,157,763	$12,185,612	$18,521,807
7	Total Non-Operating Revenue	$440,967	$300,269	$344,679	$441,485	$321,487	$854,129	$3,803,409	$4,103,678	$4,448,357	$4,889,842	$5,211,329	$6,065,458
8	Excess/(Deficiency) of Revenue Over Expenses	$1,056,509	$1,784,474	$2,185,097	$1,646,859	$1,349,336	$7,190,324	$10,431,175	$12,215,649	$14,400,746	$16,047,605	$17,396,941	$24,587,265
A	Operating Performance												
	Operating Margin	3.51%	8.06%	10.24%	7.05%	5.88%	27.42%	5.26%	5.61%	6.13%	6.21%	6.18%	8.41%
	Non-Operating Margin	2.52%	1.63%	1.92%	2.58%	1.84%	3.70%	3.02%	2.84%	2.74%	2.72%	2.64%	2.76%
	Total Margin	6.03%	9.68%	12.16%	9.64%	7.72%	31.11%	8.28%	8.45%	8.86%	8.94%	8.83%	11.17%
	Bad Debt as % of Gross Revenue	0.76%	0.66%	0.71%	0.82%	1.28%	-4.85%	0.07%	0.15%	0.21%	0.27%	0.36%	-0.06%
	Income/(Loss) From Operations	$615,542	$1,484,205	$1,840,418	$1,205,374	$1,027,849	$6,336,195	$6,627,766	$8,111,971	$9,952,389	$11,157,763	$12,185,612	$18,521,807
	Total Operating Revenue	$17,079,713	$18,138,598	$17,632,601	$16,646,552	$17,150,647	$22,254,856	$122,246,503	$140,385,101	$158,017,702	$174,664,254	$191,814,901	$214,069,757
	Total Non-Operating Revenue	$440,967	$300,269	$344,679	$441,485	$321,487	$854,129	$3,803,409	$4,103,678	$4,448,357	$4,889,842	$5,211,329	$6,065,458
	Total Revenue	$17,520,680	$18,438,867	$17,977,280	$17,088,037	$17,472,134	$23,108,985	$126,049,912	$144,488,779	$162,466,059	$179,554,096	$197,026,230	$220,135,215
	Excess/(Deficiency) of Revenue Over Expenses	$1,056,509	$1,784,474	$2,185,097	$1,646,859	$1,349,336	$7,190,324	$10,431,175	$12,215,649	$14,400,746	$16,047,605	$17,396,941	$24,587,265
	Unrestricted Net Assets	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831
	Total Net Assets	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831
	Total Gross Revenue	$72,605,707	$78,445,779	$77,192,308	$72,554,611	$76,364,840	$73,806,074	$521,318,994	$599,764,773	$676,957,081	$749,511,692	$825,876,532	$899,682,606
	Total Allowances	$54,975,781	$59,788,369	$59,015,412	$55,314,392	$58,237,023	$55,129,785	$398,699,785	$458,488,154	$517,503,566	$572,817,958	$631,054,981	$686,184,766
B	Liquidity												
1	Current Ratio	1.39	1.45	1.52	1.53	1.58	1.58	1.39	1.45	1.52	1.53	1.58	1.58
	Total Current Assets	$39,920,959	$40,575,327	$42,052,859	$43,879,418	$44,026,231	$41,686,968	$39,920,959	$40,575,327	$42,052,859	$43,879,418	$44,026,231	$41,686,968
	Total Current Liabilities	$28,624,594	$27,976,497	$27,647,048	$28,603,939	$27,792,390	$28,439,162	$28,624,594	$27,976,497	$27,647,048	$28,603,939	$27,792,390	$28,439,162
2	Days Cash on Hand	6	1	(3)	(3)	4	2	6	1	(2)	(3)	4	2
	Cash and Cash Equivalents	3,154,319	420,789	(1,295,141)	(1,356,354)	2,163,572	778,454	$3,154,319	$420,789	($1,295,141)	($1,356,354)	$2,163,572	$778,454
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	3,154,319	420,789	(1,295,141)	(1,356,354)	2,163,572	778,454	$3,154,319	$420,789	-$1,295,141	-$1,356,354	$2,163,572	$778,454
	Total Operating Expenses	16,464,171	16,654,393	15,792,183	15,441,178	16,122,798	15,918,661	$115,618,737	$132,273,130	$148,065,313	$163,506,491	$179,629,289	$195,547,950
	Depreciation Expense	513,250	513,250	513,250	513,250	513,250	513,250	$3,592,750	$4,106,000	$4,619,250	$5,132,500	$5,645,750	$6,159,000

Exhibit F

PROSPECT WATERBURY INC.

REPORT 385 - HOSPITAL CONSOLIDATED FINANCIAL DATA ANALYSIS

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
LINE	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Operating Expenses less Depreciation Expense	15,950,921	16,141,143	15,278,933	14,927,928	15,609,548	15,405,411	$112,025,987	$128,167,130	$143,446,063	$158,373,991	$173,983,539	$189,388,950
3	**Days in Net Accounts Receivable**	44	45	42	50	48	43	44	46	43	47	46	55
	Net Patient Accounts Receivable	$29,166,316	$28,493,833	$25,419,253	$25,155,000	$25,731,237	$29,688,229	$ 29,166,316	$ 28,493,833	$ 25,419,253	$ 25,155,000	$ 25,731,237	$ 29,688,229
	Due From Third Party Payers	$0	$0	$0	$1,836,598	$690,165	$2,455,418	$0	$0	$0	$1,836,598	$690,165	$2,455,418
	Due To Third Party Payers	$4,087,483	$1,991,921	$645,628	$0	$0	$0	$4,087,483	$1,991,921	$645,628	$0	$0	$0
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$25,098,833	$26,501,912	$24,773,625	$26,991,598	$26,421,402	$32,143,647	$25,098,833	$26,501,912	$24,773,625	$26,991,598	$26,421,402	$32,143,647
	Total Net Patient Revenue	$17,079,713	$18,138,598	$17,632,601	$16,646,552	$17,150,647	$22,254,856	$122,246,503	$140,385,101	$158,017,702	$174,664,254	$191,814,901	$214,069,757
4	**Average Payment Period**	54	54	54	59	55	51	54	53	53	55	54	51
	Total Current Liabilities	$28,624,594	$27,976,497	$27,647,048	$28,603,939	$27,792,390	$26,439,162	$28,624,594	$27,976,497	$27,647,048	$28,603,939	$27,792,390	$26,439,162
	Total Operating Expenses	$16,464,171	$16,654,393	$15,792,183	$15,441,178	$16,122,798	$15,918,661	$115,618,737	$132,273,130	$148,065,313	$163,506,491	$179,629,289	$195,547,950
	Depreciation Expense	$513,250	$513,250	$513,250	$513,250	$513,250	$513,250	$3,592,750	$4,106,000	$4,619,250	$5,132,500	$5,645,750	$6,159,000
	Total Operating Expenses less Depreciation Expense	$15,950,921	$16,141,143	$15,278,933	$14,927,928	$15,609,548	$15,405,411	$112,025,987	$128,167,130	$143,446,063	$158,373,991	$173,983,539	$189,388,950
	Total Gross Revenue	$72,605,707	$78,445,779	$77,192,308	$72,554,611	$76,364,840	$73,806,074	$521,318,994	$599,764,773	$676,957,081	$749,511,692	$825,876,532	$899,682,606
	Total Allowances	$54,975,781	$59,788,369	$59,015,412	$55,314,392	$58,237,023	$55,129,785	$398,699,785	$458,488,154	$517,503,566	$572,817,958	$631,054,981	$686,184,766
C	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	0.72	0.69	0.65	0.62	0.61	0.42	0.72	0.69	0.65	0.62	0.61	0.42
2	**Long Term Debt to Capitalization Ratio**	41.8	40.8	39.4	38.3	37.8	29.4	41.8	40.8	39.4	38.3	37.8	29.4
	Total Long Term Debt	$15,141,378	$15,318,647	$15,450,199	$15,436,408	$15,565,320	$15,381,332	$15,141,378	$15,318,647	$15,450,199	$15,436,408	$15,565,320	$15,381,332
	Total Net Assets	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831
	Total Long Term Debt and Total Net Assets	$36,220,118	$37,563,668	$39,261,896	$40,279,436	$41,141,119	$52,253,163	$36,220,118	$37,563,668	$39,261,896	$40,279,436	$41,141,119	$52,253,163
3	**Unrestricted Cash to Total Debt Ratio**	3.6	5.3	6.3	4.9	4.3	18.4	32.0	37.7	44.1	48.1	53.1	73.6
	Excess/(Deficiency) of Revenues Over Expenses	$1,056,509	$1,784,474	$2,185,097	$1,646,859	$1,349,336	$7,190,324	$10,431,175	$12,215,649	$14,400,746	$16,047,605	$17,396,941	$24,587,265
	Depreciation Expense	$513,250	$513,250	$513,250	$513,250	$513,250	$513,250	$3,592,750	$4,106,000	$4,619,250	$5,132,500	$5,645,750	$6,159,000
	Excess of Revenues Over Expenses and Depreciation Expense	$1,569,759	$2,297,724	$2,698,347	$2,160,109	$1,862,586	$7,703,574	$14,023,925	$16,321,649	$19,019,996	$21,180,105	$23,042,691	$30,746,265
	Total Current Liabilities	$28,624,594	$27,976,497	$27,647,048	$28,603,939	$27,792,390	$26,439,162	$28,624,594	$27,976,497	$27,647,048	$28,603,939	$27,792,390	$26,439,162
	Total Long Term Debt	$15,141,378	$15,318,647	$15,450,199	$15,436,408	$15,565,320	$15,381,332	$15,141,378	$15,318,647	$15,450,199	$15,436,408	$15,565,320	$15,381,332
	Total Current Liabilities and Total Long Term Debt	$43,765,972	$43,295,144	$43,097,247	$44,040,347	$43,357,710	$41,820,494	$43,765,972	$43,295,144	$43,097,247	$44,040,347	$43,357,710	$41,820,494
4	**Times Interest Earned**	10	17	21	16	13	70	14	14	15	15	15	20

Exhibit F

PROSPECT WATERBURY INC.

REPORT 385 - HOSPITAL CONSOLIDATED FINANCIAL DATA ANALYSIS

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
LINE	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
5	Debt Service Coverage Ratio	27	35	41	67	28	133	10	12	13	14	15	19
	Excess Revenues over Expenses	1,056,509	1,784,474	2,185,097	1,646,859	1,349,336	7,190,324	$10,431,175	$12,215,649	$14,400,746	$16,047,605	$17,396,941	$24,587,265
	Interest Expenses	104,861	104,943	105,171	102,278	103,315	102,743	$738,001	$842,944	$948,115	$1,050,393	$1,153,708	$1,256,451
	Depreciation and Amortization Expense	513,250	513,250	513,250	513,250	513,250	513,250	$3,592,750	$4,106,000	$4,619,250	$5,132,500	$5,645,750	$6,159,000
	Principal Payments	$62,267	$67,827	$68,084	$33,720	$69,850	$58,559	$1,410,958	$1,478,785	$1,546,869	$1,580,589	$1,650,439	$1,708,998
6	Equity Financing Ratio	32.5	33.9	25.8	26.4	27.1	46.9	32.5	33.9	25.8	26.4	27.1	46.9
	Total Net Assets	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831
	Total Assets	$64,844,712	$65,540,165	$92,208,944	$94,183,375	$94,233,509	$78,692,325	$64,844,712	$65,540,165	$92,208,944	$94,183,375	$94,233,509	$78,692,325
D	Additional Statistics												
1	Income from Operations	$616,542	$1,484,205	$1,640,418	$1,205,374	$1,027,849	$6,336,195	$6,627,786	$8,111,971	$9,952,389	$11,157,763	$12,185,612	$18,521,807
2	Revenue Over/(Under) Expense	$1,056,509	$1,784,474	$2,185,097	$1,646,859	$1,349,336	$7,190,324	$10,431,175	$12,215,649	$14,400,746	$16,047,605	$17,396,941	$24,587,265
3	EBITDA	$1,056,509	$1,784,474	$2,185,097	$1,646,859	$1,349,336	$7,190,324	$10,431,174	$12,215,648	$14,400,745	$16,047,604	$17,396,940	$24,587,264
4	Cash from Operations	$17,150,547	$16,204,390	$17,730,814	$17,032,944	$17,820,046	$22,742,965	$122,963,331	$141,167,721	$158,898,535	$175,931,479	$193,451,525	$216,194,490
5	Cash and Cash Equivalents	$3,164,319	$420,789	($1,295,141)	($1,356,354)	$2,163,572	$778,464	$3,164,319	$420,789	($1,295,141)	($1,356,354)	$2,163,572	$778,454
6	Net Working Capital	$11,296,365	$12,598,830	$14,405,811	$16,275,479	$16,233,841	$15,247,806	$11,296,365	$12,598,830	$14,405,811	$16,275,479	$16,233,841	$15,247,806
7	Unrestricted Assets	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831	$21,078,740	$22,245,021	$23,811,697	$24,843,028	$25,575,799	$36,871,831
8	Credit Ratings (S&P), FITCH, and Moody's)												

Exhibit F

GREATER WATERBURY HEALTH NETWORK

REPORT 385 - PARENT CORPORATION CONSOLIDATED FINANCIAL DATA ANALYSIS

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
LINE	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
1	Total Gross Revenue	$80,679,457	$87,588,120	$85,835,026	$79,966,893	$84,578,547	$81,977,717	$580,494,294	$668,082,414	$753,917,440	$833,884,333	$918,462,880	$1,000,440,597
2	Total Allowances	59,086,893	64,383,714	63,435,245	59,054,027	62,330,317	58,430,254	427,216,019	491,599,733	555,034,978	614,089,005	676,419,322	734,849,576
3	Bad Debt	596,558	608,180	613,567	663,408	1,051,170	(3,604,160)	$1,796,068	$2,404,246	$3,017,813	$3,681,221	$4,732,391	$1,128,211
4	Net Patient Revenue/Total Operating Revenue	$20,996,006	$22,596,226	$21,786,214	$20,249,458	$21,197,060	$27,151,643	$151,482,209	$174,078,435	$195,864,649	$216,114,107	$237,311,167	$264,462,810
5	Total Operating Expenses	21,990,264	22,744,359	21,892,055	21,555,755	22,006,757	$22,093,630	$155,735,297	$178,479,656	$200,371,711	$221,927,466	$243,934,223	$268,027,853
6	Income/(Loss) From Operations	($994,258)	($148,133)	($105,841)	($1,306,297)	($809,697)	$5,058,013	($4,253,088)	($4,401,221)	($4,507,062)	($5,813,359)	($6,623,056)	($1,565,043)
7	Total Non-Operating Revenue	1,041,300	854,459	1,517,103	1,132,018	946,752	1,435,654	7,792,725	8,647,184	10,164,287	11,296,305	12,243,057	13,678,711
8	Excess/(Deficiency) of Revenue Over Expenses	$47,042	$706,326	$1,411,262	($174,279)	$137,055	$6,493,667	$3,539,637	$4,245,963	$5,657,225	$5,482,946	$5,620,001	$12,113,668
A	**Operating Performance**												
1	**Operating Margin**	**-4.51%**	**-0.63%**	**-0.46%**	**-6.11%**	**-3.66%**	**17.69%**	**-2.67%**	**-2.41%**	**-2.19%**	**-2.66%**	**-2.65%**	**-0.56%**
2	**Non-Operating Margin**	**4.73%**	**3.64%**	**6.61%**	**5.29%**	**4.28%**	**5.02%**	**4.89%**	**4.73%**	**4.93%**	**4.97%**	**4.91%**	**4.92%**
3	**Total Margin**	**0.21%**	**3.01%**	**6.06%**	**-0.82%**	**0.62%**	**22.72%**	**2.22%**	**2.32%**	**2.75%**	**2.41%**	**2.25%**	**4.36%**
4	**Bad Debt as % of Gross Revenue**	**0.74%**	**0.69%**	**0.71%**	**0.83%**	**1.24%**	**-4.40%**	**0.31%**	**0.36%**	**0.40%**	**0.44%**	**0.52%**	**0.11%**
1	Income/(Loss) From Operations	($994,258)	($148,133)	($105,841)	($1,306,297)	($809,697)	$5,058,013	($4,253,088)	($4,401,221)	($4,507,062)	($5,813,359)	($6,623,056)	($1,565,043)
2	Total Operating Revenue	$20,996,006	$22,596,226	$21,786,214	$20,249,458	$21,197,060	$27,151,643	$151,482,209	$174,078,435	$195,864,649	$216,114,107	$237,311,167	$264,462,810
3	Total Non-Operating Revenue	$1,041,300	$854,459	$1,517,103	$1,132,018	$946,752	$1,435,654	$7,792,725	$8,647,184	$10,164,287	$11,296,305	$12,243,057	$13,678,711
4	Total Revenue	$22,037,306	$23,450,685	$23,303,317	$21,381,476	$22,143,812	$28,587,297	$159,274,934	$182,725,619	$206,028,936	$227,410,412	$249,554,224	$278,141,521
5	Excess/(Deficiency) of Revenue Over Expenses	$47,042	$706,326	$1,411,262	($174,279)	$137,055	$6,493,667	$3,539,637	$4,245,963	$5,657,225	$5,482,946	$5,620,001	$12,113,668
6	Unrestricted Net Assets	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474
7	Total Net Assets	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474
8	Total Gross Revenue	$80,679,457	$87,588,120	$85,835,026	$79,966,893	$84,578,547	$81,977,717	$580,494,294	$668,082,414	$753,917,440	$833,884,333	$918,462,880	$1,000,440,597
9	Total Allowances	$59,086,893	$64,383,714	$63,435,245	$59,054,027	$62,330,317	$58,430,254	$427,216,019	$491,599,733	$555,034,978	$614,089,005	$676,419,322	$734,849,576
B	**Liquidity**												
1	**Current Ratio**	**0.93**	**0.93**	**0.93**	**0.92**	**0.91**	**1.36**	**0.93**	**0.93**	**0.93**	**0.92**	**0.91**	**1.36**
	Total Current Assets	$51,785,059	$51,060,114	$51,639,872	$52,527,079	$50,956,404	$59,209,905	$51,785,059	$51,060,114	$51,639,872	$52,527,079	$50,956,404	$59,209,905
	Total Current Liabilities	$55,656,423	$55,163,163	$55,755,602	$57,097,479	$55,712,174	$43,615,410	$55,656,423	$55,163,163	$55,755,602	$57,097,479	$55,712,174	$43,615,410
2	**Days Cash on Hand**	**12**	**8**	**6**	**8**	**12**	**11**	**12**	**8**	**6**	**7**	**12**	**11**
	Cash and Cash Equivalents	$8,145,622	$5,225,814	$3,955,207	$4,695,415	$7,572,626	$7,372,971	$8,145,622	$5,225,814	$3,955,207	$4,695,415	$7,572,626	$7,372,971
	Short Term Investments	$569,688	$573,862	$574,376	$579,767	$582,572	$584,520	$569,688	$573,862	$574,376	$579,767	$582,572	$584,520
	Total Cash and Short Term Investments	$8,715,310	$5,799,676	$4,529,583	$5,275,182	$8,155,198	$7,957,491	$8,715,310	$5,799,676	$4,529,583	$5,275,182	$8,155,198	$7,957,491
	Total Operating Expenses	$21,990,264	$22,744,359	$21,892,055	$21,555,755	$22,006,757	$22,093,630	$155,735,297	$178,479,656	$200,371,711	$221,927,466	$243,934,223	$266,027,853
	Depreciation Expense	$596,558	$608,180	$613,567	$663,408	$1,051,170	$20,111	$4,031,456	$4,639,636	$5,253,203	$5,916,611	$6,967,781	$6,967,892
	Operating Expenses less Depreciation Expense	$21,393,706	$22,136,179	$21,278,488	$20,892,347	$20,955,587	$22,073,519	$151,703,841	$173,840,020	$195,118,508	$216,010,855	$236,966,442	$259,059,961

Exhibit F

GREATER WATERBURY HEALTH NETWORK

REPORT 385 - PARENT CORPORATION CONSOLIDATED FINANCIAL DATA ANALYSIS

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
LINE	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
3	**Days Revenue in Patient Accounts Receivable**	35	36	34	41	38	46	35	37	34	38	37	57
	Net Patient Accounts Receivable	$ 29,166,316	$ 28,493,833	$ 25,419,253	$ 25,155,000	$ 25,731,237	$ 39,177,208	$ 29,166,316	$ 28,493,833	$ 25,419,253	$ 25,155,000	$ 25,731,237	$ 39,177,208
	Due From Third Party Payers	$0	$0	$0	$1,836,598	$690,165	$2,455,418	$0	$0	$0	$1,836,598	$690,165	$2,455,418
	Due To Third Party Payers	$4,367,483	$2,291,921	$945,628	$300,000	$300,000	$300,000	$4,367,483	$2,291,921	$945,628	$300,000	$300,000	$300,000
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$24,798,833	$26,201,912	$24,473,625	$26,691,598	$26,121,402	$41,332,626	$24,798,833	$26,201,912	$24,473,625	$26,691,598	$26,121,402	$41,332,626
	Total Net Patient Revenue	$20,996,006	$22,596,226	$21,786,214	$20,249,458	$21,197,060	$27,151,643	$151,482,209	$174,078,435	$195,864,649	$216,114,107	$237,311,167	$264,462,810
4	**Average Payment Period**	78	77	79	85	82	59	78	77	78	80	79	61
	Total Current Liabilities	55,656,423	55,163,163	55,755,602	57,097,479	55,712,174	43,615,410	55,656,423	55,163,163	55,755,602	57,097,479	55,712,174	43,615,410
	Total Operating Expenses	21,990,264	22,744,359	21,892,055	21,555,755	22,006,757	22,093,630	155,735,297	178,479,656	200,371,711	221,927,466	243,934,223	266,027,853
	Depreciation Expense	596,558	608,180	613,567	663,408	1,051,170	20,111	4,031,456	4,639,636	5,253,203	5,916,611	6,967,781	6,987,892
	Total Operating Expenses less Depreciation Expense	21,393,706	22,136,179	21,278,488	20,892,347	20,955,587	22,073,519	151,703,841	173,840,020	195,118,508	216,010,855	236,966,442	259,039,961
	Total Gross Revenue	$80,679,457	$87,588,120	$85,835,026	$79,966,893	$84,578,547	$81,977,717	$580,494,294	$668,082,414	$753,917,440	$833,884,333	$918,462,880	$1,000,440,597
	Total Allowances	$59,086,893	$64,383,714	$63,435,245	$59,054,027	$62,330,317	$58,430,254	$427,216,019	$491,569,733	$555,034,978	$614,089,005	$676,419,322	$734,849,576
C	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	0.53	0.55	0.52	0.53	0.54	0.41	0.53	0.55	0.52	0.53	0.54	0.41
2	**Long Term Debt to Capitalization Ratio**	34.7	35.6	34.4	34.6	35.3	28.9	34.7	35.6	34.4	34.6	35.3	28.9
	Total Long Term Debt	$15,902,245	$16,151,607	$15,685,153	$15,744,695	$15,948,250	$15,381,332	$15,902,245	$16,151,607	$15,685,153	$15,744,695	$15,948,250	$15,381,332
	Total Net Assets	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474
	Total Long Term Debt and Total Net Assets	$45,876,266	$45,356,412	$45,598,849	$45,533,921	$45,233,153	$53,197,806	$45,876,266	$45,356,412	$45,598,849	$45,533,921	$45,233,153	$53,197,806
3	**Unrestricted Cash to Total Debt Ratio**	0.9	1.8	2.8	0.7	1.7	11.0	10.6	12.5	15.3	15.6	17.6	32.4
	Excess/(Deficiency) of Revenues Over Expenses	$47,042	$706,326	$1,411,262	-$174,279	$137,055	$6,493,667	$3,539,637	$4,245,963	$5,657,225	$5,482,946	$5,620,001	$12,113,668
	Depreciation Expense	$596,558	$608,180	$613,567	$663,408	$1,051,170	$20,111	$4,031,456	$4,639,636	$5,253,203	$5,916,611	$6,967,781	$6,987,892
	Excess of Revenues Over Expenses and Depreciation Expense	$643,600	$1,314,506	$2,024,829	$489,129	$1,188,225	$6,513,778	$7,571,093	$8,885,599	$10,910,428	$11,399,557	$12,587,782	$19,101,560
	Total Current Liabilities	$55,656,423	$55,163,163	$55,755,602	$57,097,479	$55,712,174	$43,615,410	$55,656,423	$55,163,163	$55,755,602	$57,097,479	$55,712,174	$43,615,410
	Total Long Term Debt	$15,902,245	$16,151,607	$15,685,153	$15,744,695	$15,948,250	$15,381,332	$15,902,245	$16,151,607	$15,685,153	$15,744,695	$15,948,250	$15,381,332
	Total Current Liabilities and Total Long Term Debt	$71,558,668	$71,314,770	$71,440,755	$72,842,174	$71,660,424	$58,996,742	$71,558,668	$71,314,770	$71,440,755	$72,842,174	$71,660,424	$58,996,742
4	**Times Interest Earned**	0.45	6.72	13.40	-1.70	1.32	63.14	4.79	5.03	5.96	5.21	4.86	9.63

Exhibit F

GREATER WATERBURY HEALTH NETWORK

REPORT 385 - PARENT CORPORATION CONSOLIDATED FINANCIAL DATA ANALYSIS

		MTD						YTD					
LINE	DESCRIPTION	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017
5	Debt Service Coverage Ratio	12	21	31	18	18	113	6	7	8	8	8	12
	Excess Revenues over Expenses	$47,042	$706,326	$1,411,262	($174,279)	$137,055	$6,493,667	$3,539,637	$4,245,963	$5,657,225	$5,482,946	$5,620,001	$12,113,668
	Interest Expenses	$104,911	$105,108	$105,322	$102,415	$103,438	$102,852	$739,192	$844,300	$949,622	$1,052,037	$1,155,475	$1,258,327
	Depreciation and Amortization Expense	$596,558	$608,180	$613,567	$663,408	$1,051,170	$20,111	$4,031,456	$4,639,636	$5,253,203	$5,916,611	$6,967,781	$6,987,892
	Principal Payments	$62,267	$67,827	$68,084	$33,720	$69,850	$58,559	$1,410,958	$1,478,785	$1,546,869	$1,580,589	$1,650,439	$1,708,998
6	Equity Financing Ratio	46.2	44.6	32.4	31.6	31.1	38.0	46.2	44.6	32.4	31.6	31.1	38.0
	Total Net Assets	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474
	Total Assets	$64,844,712	$65,540,165	$92,208,944	$94,183,375	$94,233,509	$99,648,065	$64,844,712	$65,540,165	$92,208,944	$94,183,375	$94,233,509	$99,648,065
D	Additional Statistics												
1	Income from Operations	($994,258)	($148,133)	($105,841)	($1,306,297)	($809,697)	$5,058,013	($4,253,088)	($4,401,221)	($4,507,062)	($5,813,359)	($6,623,056)	($1,565,043)
2	Revenue Over/(Under) Expense	$47,042	$706,326	$1,411,262	($174,279)	$137,055	$6,493,667	$3,539,637	$4,245,963	$5,657,225	$5,482,946	$5,620,001	$12,113,668
3	EBITDA	$47,042	$706,326	$1,411,262	($174,279)	$137,055	$6,493,667	$3,539,637	$4,245,963	$5,657,225	$5,482,946	$5,620,001	$12,113,668
4	Cash from Operations	$21,085,562	$22,680,827	$21,904,333	$20,860,386	$21,693,726	$27,663,815	$152,349,903	$175,030,730	$196,935,063	$217,595,449	$239,189,176	$266,852,990
5	Cash and Cash Equivalents	$8,715,310	$5,799,676	$4,529,583	$5,275,182	$8,155,198	$7,957,491	$8,715,310	$5,799,676	$4,529,583	$5,275,182	$8,155,198	$7,957,491
6	Net Working Capital	($3,871,364)	($4,103,049)	($4,115,730)	($4,570,400)	($4,755,770)	$15,594,495	($3,871,364)	($4,103,049)	($4,115,730)	($4,570,400)	($4,755,770)	$15,594,495
7	Unrestricted Assets	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474	$29,974,021	$29,204,805	$29,913,696	$29,789,226	$29,284,903	$37,816,474
8	Credit Ratings (S&P), FITCH, and Moody's)												

User, OHCA

From: Roberts, Karen
Sent: Wednesday, January 31, 2018 3:12 PM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: Prospect Waterbury Docket Number 15-32017_Compliance Material Submission and Condition #16

From: Cotto, Carmen
Sent: Wednesday, January 31, 2018 2:53 PM
To: 'colleen713.smith@gmail.com' <colleen713.smith@gmail.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Prospect Waterbury Docket Number 15-32017_Compliance Material Submission and Condition #16

Dear Colleen:

Please address the following in reference to Docket number 15-32017-486:

1) OHCA is requesting that all compliance filings from the hospital staff, first go to you, as the Independent Monitor ("IM"), and then you file the material with OHCA. This will provide OHCA with verification that you have reviewed the material to determine compliance to the order prior to OHCA's review of the material. The submission of compliance documents by the hospitals' staff directly to OHCA and only copied to you does not allow OHCA to clearly identify the IM's involvement in the process of reviewing and submitting the documents.

2) Condition #16 stipulates that the IM is "…*to be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order*". The IM is required to look at the material filed and verify compliance for each condition. OHCA's records show that no reports have been filed regarding this task. Please submit to OHCA a report of your review of Prospect's Waterbury material to date that verifies compliance for each of the conditions set forth in the Order. In terms of how this report could be formatted, OHCA suggests to refer back to the IM's work plan documents submitted to OHCA on December 9, 2016 which lists all of the conditions and actions that will be taking place then add a column to this document describing the IM's observations on how compliance for each of the conditions listed has been met. After this catch up IM report, please file this on a semi-annual basis through the end of the IM contractual period.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Sincerely,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph